Public Document Pack

Leeds CITY COUNCIL

# SCRUTINY BOARD (ADULTS,HEALTH & ACTIVE LIFESTYLES)

**Meeting to be held in remotely on**
**Tuesday, 23rd June, 2020 at 2.00 pm**

***(A pre-meeting will take place for ALL Members of the Board at 1.45 p.m.)***

**MEMBERSHIP**

**Councillors**

| | | |
|---|---|---|
| C Anderson | - | Adel and Wharfedale; |
| J Elliott | - | Morley South; |
| N Harrington | - | Wetherby; |
| H Hayden (Chair) | - | Temple Newsam; |
| M Iqbal | - | Hunslet and Riverside; |
| C Knight | - | Weetwood; |
| G Latty | - | Guiseley and Rawdon; |
| S Lay | - | Otley and Yeadon; |
| D Ragan | - | Burmantofts and Richmond Hill; |
| A Smart | - | Armley; |
| P Truswell | - | Middleton Park; |
| A Wenham | - | Roundhay; |

**Co-opted Member (Non-voting)**

Dr J Beal - Healthwatch Leeds

Note to observers of the meeting: To remotely observe this meeting, please click on the 'View the Webcast' link which will feature on the meeting's webpage (linked below) ahead of the meeting. The webcast will become available at the commencement of the meeting.
http://democracy.leeds.gov.uk/ieListDocuments.aspx?CId=1090&MId=9997&Ver=4

**Principal Scrutiny Adviser:**
**Steven Courtney**
**Tel: (0113) 37 88666**

# A G E N D A

| Item No | Ward/Equal Opportunities | Item Not Open | | Page No |
|---|---|---|---|---|
| 1 | | | **APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS**<br><br>To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded).<br><br>(* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting). | |
| 2 | | | **EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC**<br><br>1. To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report.<br><br>2. To consider whether or not to accept the officers recommendation in respect of the above information.<br><br>3. If so, to formally pass the following resolution:-<br><br>**RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:<br><br>**No exempt items have been identified.** | |

| | | | | |
|---|---|---|---|---|
| 3 | | | **LATE ITEMS**<br><br>To identify items which have been admitted to the agenda by the Chair for consideration.<br><br>(The special circumstances shall be specified in the minutes.) | |
| 4 | | | **DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS**<br><br>To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct. | |
| 5 | | | **APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES**<br><br>To receive any apologies for absence and notification of substitutes. | |
| 6 | | | **MINUTES - 11 FEBRUARY 2020**<br><br>To approve as a correct record the minutes of the meeting held on 11 February 2020. | 7 - 14 |
| 7 | | | **UPDATE ON CORONAVIRUS (COVID19) PANDEMIC – RESPONSE AND RECOVERY PLAN**<br><br>To receive a report from the Head of Democratic Services in relation to the ongoing progress made by the council working with partners and communities in response to the unprecedented COVID-19 pandemic. | 15 - 124 |
| 8 | | | **CORONAVIRUS (COVID19) PANDEMIC - HEALTH INEQUALITIES**<br><br>To receive a report from the Head of Democratic Services introducing specific information and analysis of health inequalities associated with the COVID-19 pandemic. | 125 - 232 |
| 9 | | | **WORK SCHEDULE**<br><br>To consider the Scrutiny Board's initial work schedule for June – August 2020. | 233 - 246 |

10

**DATE AND TIME OF NEXT MEETING**

Tuesday, 14 July 2020 at 2:00pm (pre-meeting for all Scrutiny Board members at 1:45pm).

**THIRD PARTY RECORDING**

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts on the front of this agenda.

Use of Recordings by Third Parties – code of practice

a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.

b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

**Webcasting**

**Please note** – the publically accessible parts of this meeting will be filmed for live or subsequent broadcast via the City Council's website.

At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed.

**SCRUTINY BOARD (ADULTS,HEALTH & ACTIVE LIFESTYLES)**

**TUESDAY, 11TH FEBRUARY, 2020**

**PRESENT:** Councillor H Hayden in the Chair

Councillors C Anderson, J Elliott,
N Harrington, M Iqbal, G Latty, A Smart,
P Truswell and A Wenham

**CO-OPTEE:** Dr J Beal – Healthwatch Leeds

**84 Appeals Against Refusal of Inspection of Documents**

There were no appeals.

**85 Exempt Information - Possible Exclusion of the Press and Public**

There was no exempt information.

**86 Late Items**

There were no late items.

**87 Declaration of Disclosable Pecuniary Interests**

There were no declarations.

**88 Apologies for Absence and Notification of Substitutes**

Apologies for absence were submitted on behalf of Councillors C Knight, S Lay and D Ragan.

There were no substitute members in attendance.

**89 Minutes - 7 January 2020**

**RESOLVED –** That the minutes of the meeting held on 7 January 2020 be confirmed as a correct record.

**90 Maternity and Neonatal Services in Leeds - proposed reconfiguration of services**

The report of the Head of Democratic Services introduced the proposed reconfiguration of maternity and neonatal services in Leeds alongside details of the associated public consultation.

Appendices to the report gave an overview of Maternity and Neonatal Services in Leeds and introduced the proposals for the reconfiguration of services.

The following were in attendance for this item:

- Dr Kelly Cohen, Consultant in Fetal Medicine and Obstetrics & Clinical Director, Women's CSU (Leeds Teaching Hospitals NHS Trust)
- Dr Hannah Shore, Lead Clinician Neonatal Service (Leeds Teaching Hospitals NHS Trust)
- Dr Jane Mischenko, Lead Strategic Commissioner: Children & Maternity Care, (NHS Leeds Clinical Commissioning Group)
- Sarah Halstead, Senior Service Specialist (NHS England Specialised Commissioning)
- Shak Rafiq, Communications Manager (NHS Leeds Clinical Commissioning Group)
-

The Board was shown a short video presentation with regard to the proposed reconfiguration of Maternity and Neonatal Services in Leeds.

The following was highlighted:

- Midwifery led care had been highlighted as an issue from the Maternity Strategy and the proposed reconfiguration of services aimed to deliver this. There was clear evidence in the benefits of the proposals.
- Existing maternity arrangements at St James and LGI were virtually identical with different neonatal services. This caused problems with having to transfer babies between the sites and also mothers being separated from babies where specialist neonatal care was required.

In response to questions from the Board, the following was discussed:

- Formal public consultation was being undertaken due to the significance of the proposed changes.
- There had been recent changes to services at St James's which had had a positive impact. This had involved some pre-term deliveries being referred to LGI.
- Impact on families when babies are transferred between the existing two hospital sites.
- There were workforce challenges due to the size of the delivery unit at St James's and the need to resource the unit based on its maximum capacity.
- Leeds Teaching Hospitals Trust (LTHT) worked closely with other Trusts including Harrogate to provide neonatal care and how the trusts can work better together.
- The consultation process included targeting seldom heard stakeholders through Voluntary Action Leeds, other community groups and those with English as a second language. Translators had been available at drop in events.

- Mental health and emotional wellbeing had been an important part of the Maternity Strategy and there were pathways for perinatal mental health care.
- Provision of bereavement services – there was co-ordination between in house teams and external services (including hospices). There was also support available for fathers.
- The timescales and forthcoming consultations events were also considered.

Members of the Board were invited to visit both maternity and neonatal units during the consultation period.

The Chair thanked those in attendance for their attendance and presentation; adding that the level of engagement undertaken, including the involvement of the Scrutiny Board, prior to formal consultation had been pleasing to see and could usefully inform the approach for proposed changes across other service areas within the Leeds boundary and beyond.

**RESOLVED –** That the report and accompanying information be noted along with the associated key activities and timescales.

## 91 Leeds Teaching Hospitals NHS - Access to Services

The report of the Head of Democratic Services introduced a Leeds Teaching Hospitals NHS Trust report on access to services, particularly related to dermatology and spinal surgery services alongside the latest Integrated Quality and Performance Report (January 2020) and an overview of the West Yorkshire Association of Acute Trusts (WYATT).

The following were appended to the report:

- Leeds Teaching Hospital Trust's Integrated Quality and Performance Report
- West Yorkshire Association of Acute Trusts Annual Report 2018/19.

The following were in attendance for this item:

- Julian Hartley, Chief Executive (Leeds Teaching Hospitals NHS Trust)
- Clare Smith, Director of Operations (Leeds Teaching Hospitals NHS Trust)
- Matt Graham, WYAAT Programme Director.(Leeds Teaching Hospitals NHS Trust)
- Helen Lewis, Interim Director of Commissioning, Acute, Mental Health and Learning Disability Services (NHS Leeds Clinical Commissioning Group)

Leeds Teaching Hospitals NHS Trust report on access to services particularly focused on dermatology and spinal surgery services and provided an overview of the work of West Yorkshire Association of Acute Trusts (WYATT).

The report also presented the latest Integrated Quality and Performance Report (January 2020)

Dermatology Services

The following was highlighted:

- Services were based at Chapel Allerton hospital.
- 81% of patients were commissioned by Leeds CCG with 11% coming from Calderdale.
- There had been an increase in waiting times over the past 18 to 24 months largely as a result of increased referrals from Calderdale putting pressure on the delivery of the service. There had been a response with the provision of additional clinics and work was ongoing with Calderdale to address the impact of increased referrals.
- Patients were taken on a clinical needs order and then chronological order.
- Waiting times were currently around 11 weeks.

In response to questions, a number of matters were raised and discussed, including:

- The development of dermatology networks to address the national workforce pressures.
- Innovative working practices including the use of tele-dermatology.
- It was a challenge at a West Yorkshire level to meet capacity and demand and a network was being developed across West Yorkshire.
- WYAAT held a monthly meeting to discuss key pressure areas. There had been difficulties in Calderdale as lit had not been possible to attract and recruit consultant dermatologists to the area.
- Concern that LTHT was having to take more patients from other areas and this affected treatment / waiting times for Leeds residents.
- Concern that the issues affecting the dermatology service represented 'the tip of the iceberg' and other service areas could be facing similar pressures.

It was re-emphasised that there were workforce challenges across West Yorkshire and nationally. Consideration was being given to how demand could be managed within the context of the workforce challenges.

Spinal Surgery Services

The following was highlighted:

- Specialist spinal surgery services in Leeds were provided on a tertiary basis, covering West Yorkshire and Harrogate.
- Most of the work was based at LGI with some out-patient clinics provided at Wharfedale.
- There had been 52 patients waiting for spinal surgery across West Yorkshire over the 52 week waiting list target; 15 of these patients

coming from Leeds. This had reduced over the past two years with considerable improvement over the past year.
- Reference was made to the 'Getting it Right First Time Program' which was focused on identifying efficiencies within the service.

In response to questions, a number of matters were raised and discussed, including:

- Concern that there had been no 52-week waits prior to 2017/18, and the current pressures were a legacy of the 2017/18 approach to winter pressures and the cancellation of planned surgical procedures.
- Patients who had been waiting for longer periods had less clinically urgent conditions than others.
- Challenges facing the service – allocation of resources; complexity of cases often with other health issues and the impact of this on the wider service.
- There had been a growth in spinal surgery and a larger number of complex cases.
- 58% of patients were seen within the 18 week referral to treatment timescale which was above average nationally.
- The longest waiting time for a patient had been 72 weeks.

The Trust was asked to provide the following information for members of the Scrutiny Board:
- The average waiting time for spinal surgery

<u>Integrated Quality and Performance Report (IQPR)</u>

An overview was given of the Performance Report. The following was highlighted:

- The report drew together all the different strands of quality and performance across Leeds Teaching Hospitals.
- There were a number of quality markers to comment on which included environment, workforce and patient experience.

In response to questions from the Board, the following as discussed:

- Operations cancelled on the day – there were various reasons but main reasons included unavailability of beds or insufficient theatre time. There was also intense pressure in the winter months particularly on urgent care and admissions. There had been an improvement during the last year.
- Cancer referrals – Leeds Teaching Hospitals NHS Trust was the specialist referral service for the region and relied upon timely referrals from others to meet the 62 day standard. Work was ongoing with WYAAT to improve the patient pathway.

- Referral to Treatment – there were significant issues with backlogs for spinal surgery and some other specialty areas.
- Readmission to hospital – Leeds compared favourably nationally and readmission rates were considerably below peer trusts. It was also noted that the data included repeat attendance by patients.
- An issue was reported regarding a recent case of admission to A&E which was not resolved satisfactorily due to waiting times and concerns that the service appeared to be understaffed. It was reported that there had been a focus on recruitment and retention and although the service was under pressure, the length of time in this case was not within target.
- Funding – The Trust had met their control total and had been eligible for further monies which had been spent on capital equipment.
- The waste reduction programme was linked to quality goals and there had been work within clinical teams to identify waste reduction and improvements. The trust had been rated as outstanding by the CQC for use of resources.
- Rise in the number of super stranded patients – there was a variety of reasons for this including varying clinical reasons and those waiting for transfer of care. Figures tended to rise over the winter period.
- Challenges highlighted included reducing times for spinal operations, reducing length of stay in hospital and reducing pressures on A&E. The main challenge was how to do the very best for patients in Leeds.

The Trust was asked to provide the following information for members of the Scrutiny Board:

- The total number of operations completed across the Trust in a given time period (ideally December 2019)

The Chair thanked those in attendance for this item.

**RESOLVED –**

(1) That the report and accompanying information be noted.
(2) That the additional information identified at the meeting be provided to members of the Board.

## 92 Chair's Update

The report of the Head of Democratic Services provided an opportunity to formally outline some of the areas of work and activity of the Chair since the previous Board meeting in January 2020.

- Co-Chaired HealthWatch Leeds event on Mental Health Crisis across Leeds. An interactive event with a number of different table discussions that involved a range of stakeholders including NHS commissioners, NHS Mental Health Service Providers, Third Sector organisations, GPs and service users.

- An update on the mandatory Joint Health Scrutiny Committee considering proposals to reconfigure specialist vascular services. A further meeting of the Joint Committee was scheduled for 24 February 2020.
- An outline of a meeting with Leeds Local Medical Committee scheduled for 21 February 2020; which would pick up on the work being undertaken on supporting Nursing Care Homes supporting GP services (particularly Out of Hours Service) in certifying expected deaths.
- Outline of a recent pre-planning meeting around the East Leeds Extension Southern and Middle Quadrants and the engagement of the NHS in likely impacts and planning for the future. Arrangements were being put in place for further discussions.

**RESOLVED –** That the report and update provided be noted.

## 93 Work Schedule

The report of the Head of Democratic Services invited Members to consider the Board's work schedule for the remainder of the 2019/20 Municipal Year.

A copy of the outline work schedule and Executive Board minutes were appended to the report.

The Principal Scrutiny Adviser presented the report. The following was highlighted:

- Additional meetings for Adults Safeguarding and Public Consultation on Reconfiguration of Maternity/Neonatal Services.
- Additional meeting to be arranged regarding the Aireborough Leisure Centre referral.

**RESOLVED –** That the repot and Board's work schedule for the remainder of the 2019/20 Municipal Year be noted.

## 94 Date and Time of Next Meeting

Tuesday, 31 March 2020 at 1.30 p.m.

(Pre-meeting for all Board Members at 1.00 p.m.)

This page is intentionally left blank

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 0113 37 88666

**Report of Head of Democratic Services**

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

**Date: 23 June 2020**

**Subject: Update on Coronavirus (COVID19) pandemic – Response and Recovery Plan**

| | | |
|---|---|---|
| Are specific electoral wards affected?<br>If yes, name(s) of ward(s): | ☐ Yes | ☒ No |
| Has consultation been carried out? | ☐ Yes | ☒ No |
| Are there implications for equality and diversity and cohesion and integration? | ☒ Yes | ☐ No |
| Will the decision be open for call-in? | ☐ Yes | ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, access to information procedure rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## 1. Purpose of this report

1.1 This report provides the Scrutiny Board with an update on the ongoing progress made by the council working with partners and communities in response to the unprecedented COVID-19 pandemic.

1.2 The Council's Chief Executive provided a comprehensive update report to the Executive Board during its meeting on 19 May 2020 on developments surrounding the Council's Response and Recovery Plan – which includes activity across partner organisations. This report has therefore been appended for the Scrutiny Board's attention and consideration.

1.3 However, due to the fast paced nature of developments of this issue, the relevant Lead Executive Board Members, the Director of Adults and Health, the Director of Public Health and representatives from across local NHS bodies have been invited to attend the meeting to provide a further verbal update on the latest position with regard to those service areas that fall within the remit of the Scrutiny Board (Adults, Health and Active Lifestyles).

## 2. Background information

2.1 The initial governance and delivery structure to drive the response to the coronavirus outbreak, including an initial Response and Recovery Plan, was considered by the Executive Board in March 2020. A further update report by the Chief Executive, which included an updated version of the Response and Recovery Plan, was then reported to the Executive Board during its first public remote meeting held on 22 April 2020 (Link to Executive Board meeting agenda 22-04-20).

2.2 During April, arrangements were also put in place for each of the Council's Scrutiny Board Chairs to receive regular briefings from their respective Lead Directors and Executive Members to review the COVID-19 response. During May, these arrangements were extended so that, on a fortnightly basis, all Scrutiny Board Members were also being engaged in those briefings (as part of remote working groups).

2.3 As part of its first public remote meeting, the Scrutiny Board (Adults, Health and Active Lifestyles) is continuing to focus its attention on how the Council and its partners are working collaboratively to support the broad range of patients, service users and stakeholders across the health and care system during such an unprecedented and difficult period.

## 3. Main issues

3.1 During the working group discussions, members of the Scrutiny Board have raised and considered a range of matters, including:

- **Access to Health and Care Services** – patient / service user access to local health and care services.
- **Capacity of Health and Care Services** – how services have responded to the COVID-19 pandemic and overall capacity to deliver services.
- **Care Homes and Homecare** – the levels of care and support provided under extremely difficult and changing / challenging circumstances.
- **Personal Protective Equipment (PPE)** – including ongoing issues around quality; the exponential rise in costs; and establishing and maintain a sustainable supply chain across Leeds' health and care system
- **Testing** – the importance of establishing and maintaining robust and reliable arrangements for testing health and care staff; testing patients / service users in health and care settings; alongside more general testing arrangements for the public.
- **Health Inequalities** and the impact on deprived communities and specific populations.
- **Collaboration and partnership working** – details of the coordinated efforts of the Council and NHS partners; alongside some of the challenges caused by a national response and how that related to / reflected local needs and priorities.
- **Rate of infection** – the issues caused by a lack of a more localised 'R' number; and the work being done to explore the possibility of establishing an 'R' number for Leeds and/or West Yorkshire.
- **Learning points and practices** – included some of the more positive impacts around changes in practice, flexible ways of working and the general increase and broadening out of the use of digital technology.

3.2 Due to the fast paced nature of developments of this issue, the Board will be briefed on the latest position with regard to those service areas that fall within the remit of the Scrutiny Board (Adults, Health and Active Lifestyles), including the areas identified above. However, it should be noted that issues in relation to health inequalities are due to be considered as part of a separate agenda item.

## 4. Corporate considerations

### 4.1 Consultation and engagement

4.1.1 An invitation to this meeting has been extended to the Executive Board Member for Adults, Health and Active Travel; the Director of Adults and Health; the Director of Public Health; and representatives from across local NHS bodies have been invited to attend the meeting to provide a further verbal update on the latest position with regard to those service areas that fall within the remit of the Scrutiny Board (Adults, Health and Active Lifestyles).

### 4.2 Equality and diversity / cohesion and integration

4.2.1 The appended report to the Executive Board references the work ongoing to specifically review inequalities in targeted communities, with equality and diversity being built into the consideration of all citizens and communities work.

### 4.3 Council policies and the Best Council Plan

4.3.1 Within the appended report to the Executive Board, reference is made to the work being undertaken to adapt the version of the Best Council Plan that was agreed at February Full Council to ensure that the COVID context is accurately captured.

Climate Emergency

4.3.2 The appended report to Executive Board also acknowledges that as the Council develops its recovery plans, these will incorporate the promotion of more sustainable and healthy movement of people; exploring new ways of working, adopting digital technology and home working; emphasising the value of green spaces and local community as well as looking to focus on green investments

### 4.4 Resources, procurement and value for money

4.4.1 Given the significance of the financial implications of coronavirus, arrangements are in place for the Council's Executive Board to receive separate and more detailed reports on this matter. The Council's Strategy and Resources Scrutiny Board will also be maintaining oversight of the Council's financial management strategy in accordance with its remit.

### 4.5 Legal implications, access to information, and call-in

4.5.1 This report has no specific legal implications.

### 4.6 Risk management

4.6.1 The risks related to coronavirus will continue to be monitored through the Council's existing risk management processes.

## 5. Conclusions

5.1 As part of its first public remote meeting, the Scrutiny Board (Adults, Health and Active Lifestyles) is continuing to focus its attention on how the Council and its partners are working collaboratively to support the broad range of patients, service users and stakeholders across the health and care system during such an unprecedented and difficult period. This report therefore introduces an update on the ongoing progress made by the council working with partners and communities in response to the

unprecedented COVID-19 pandemic. However, due to the fast paced nature of developments of this issue, the relevant Lead Executive Board Member, Directors and NHS representatives have also been invited to provide a further verbal update on the latest position with regard to those service areas that fall within the remit of the Scrutiny Board (Adults, Health and Active Lifestyles).

## 6. Recommendations

6.1 The Scrutiny Board is asked to consider the information presented during the meeting and determine whether there are any particular issues or areas it would like to focus on in more detail as part of its next meeting scheduled for 14 July 2020.

## 7. Background documents[1]

7.1 None.

[1] The background documents listed in this section are available to download from the council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Report authors: Wasim Feroze/Mariana Pexton
Tel: 0113 37 88805

**Report of the Chief Executive**

**Report to Executive Board**

**Date: 19 May 2020**

**Subject:** Update on Coronavirus (COVID19) pandemic – Response and Recovery Plan

| | | |
|---|---|---|
| Are specific electoral wards affected?<br>If yes, name(s) of ward(s): | ☐ Yes | ☒ No |
| Has consultation been carried out? | ☒ Yes | ☐ No |
| Are there implications for equality and diversity and cohesion and integration? | ☒ Yes | ☐ No |
| Will the decision be open for call-in? | ☒ Yes | ☐ No |
| Does the report contain confidential or exempt information?<br>If relevant, access to information procedure rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## Summary

## 1. Main issues

- The unprecedented national and local developments have continued since the last report to Executive Board, with the coronavirus pandemic creating a huge global challenge. Many people have been impacted personally with the loss or illness of a loved one, having to self-isolate and living through lockdown with such significant economic and social implications. Our relentless focus has been to mobilise the city to help minimise the effects, especially on the most vulnerable, and to keep the people of the city safe. This will continue to be out focus through this next challenging phase.

- Once again, it is not possible to do justice to all the work that has been done in the city, by our communities, our partners, and by the council. This report describes the approach that has been taken, some of the impacts of that work, and some of the challenges ahead. The multi-agency arrangements described in previous Executive Board papers have continued and been further developed to deal with new challenges, and will be continually reviewed given the dynamic nature of the pandemic. Regular and extensive communications have continued to the public, councillors, MPs, partners, and staff, and we plan to continue this approach.

- Whilst we have continued to focus on our response on a range of issues, including for example care homes this month, we have also started preparation for recovery following the national approach and being informed by learning and research from others. In broad terms, we can view the next phases as follows, with the first one being the primary focus of this month's report:
    - **Responding to the virus and its effects, safely lifting lockdown**
    - Living with the virus in the population, where social distancing has to be maintained
    - A new normal, most likely once a vaccination is available

- Whilst social distancing remains key for public health reasons, the overall framework that we are using to lift lockdown will be to use test, trace and outbreak management to ensure:
    - **Safe travel** ensuring the safe use of highways and public transport and encouraging active travel where possible.
    - **Safe public spaces** with physical distancing in communities, district centres and the city centre.
    - **Safe delivery of services** including health and social care, and other public services.
    - **Safe education** as more children and young people return to schools, colleges and nurseries.
    - **Safe working** with physical distancing in workplaces and coordination between large employers to avoid peaks of movement.

- We will need everybody's continued cooperation to ensure restrictions can be eased safely, enabling us to support a strong public health response and strong economic recovery approach, delivering public services while continuing to protect and support vulnerable citizens. Clear communications and effective public engagement during this next phase, to avoid a second peak, will be key. To complement the national messaging, our local messaging about a safe city is covered in the infographic attached to this report and can be summarised as:

    - Stay at home if you can
    - Maintain social distancing if you go out
    - Wash your hands regularly and for 20 seconds
    - Stay at home and isolate if you or anyone in your household has symptoms
    - Limit contact with other people
    - Work at home if you can
    - Go to work if it is safe and you can maintain social distancing
    - Only use public transport where necessary, and wear a face covering
    - Continue to stay at home if you are shielded

- The report describes:
    - the range of national developments and announcements since the last report, covering all aspects from testing, tracking, tracing, PPE, advice for schools and support for businesses, developments on those "shielded", and local government funding and
    - the local approach to planning, governance and delivery for this unprecedented scenario, in line with the Civil Contingencies Act 2004, in particular the Response and Recovery Plan, the multi-agency governance arrangements, and the broader West Yorkshire Local Resilience Forum context with its links to the national command and control arrangements
    - the approach to easing restrictions in the city in a way that keeps the city safe, , which will be a major challenge for the city and the country

- There is a section on each of the themes within the Response and Recovery Plan, describing progress and issues, overseen by Gold Strategic Recovery Group (SCG), as follows:
    - ***Silver Health and Social Care Group*** – Significant focus on support to care homes as the response in those is still a huge risk for further deaths/illness and infection spread, so focus on PPE, responding to hospital discharges, ensuring a healthy workforce, support to providers. Gradual resumption of planned surgery and screening at hospitals. Consideration of how best community services are reintroduced, especially for the most vulnerable. Testing - ensuring capacity and coordination for all eligible groups (including anticipated pop-up sites); further support for care homes; planning for introduction of national approach to contact tracing, with the hope that this can be lodged within local arrangements. Children's social care preparing for a spike in demand.
    - ***Citizens and Communities Silver Group*** – maintaining the helpline and volunteering/food support for the vulnerable; third sector sustainability, further impact on inequality and poverty (including digital divide). Planning for key service resumption in communities in a safe way, with an additional bronze group focussing on this e.g. household waste sites, schools and community hubs. Consideration about street support and LASBT. Backlogs in key services – e.g. registrars and licensing to be addressed. Vulnerable children and connections between services important in this context, likewise with health colleagues who are concerned about vulnerable groups without good access to services.
    - ***Silver Economy and Business Group*** -Continuing effective business engagement focusing on practicalities of transitional arrangements, most notably with anchor institutions, major retailers and representative organisations; ensuring grant payments are made quickly and effectively, and schemes developed with partners where needed; rapid review of the Inclusive Growth Strategy (including further alignment to Health and Wellbeing and Climate Emergency strategies).
    - ***Infrastructure and Supplies Silver Group*** – practical challenges of social distancing in the city and district centres, public transport use/commuter concerns, working with employers regarding returning workers, safe routes to schools, additional cycling and pedestrian routes.
    - ***Silver Organisational Groups -*** **Organisational response** – workspace and building usage, workforce planning, maintaining productivity, health, safety and wellbeing (including method statements where needed); service resumption, expansion and maintenance; trade union engagement, ICT issues, financial position/budget impact.
    - ***Bronze groups*** – there are an important range of bronze tasking groups operating to progress key issues, often that fall between Silver groups. Some of these are more specifically within health and social care, with others bring broader city-wide groups, the current list includes: Domestic Violence and Abuse Officer Group; Supporting the Financially Vulnerable; Food Provision – Planning; Recovery – Return to City Estates; Recovery – Returning to Public Spaces; Recovery – Reopening Schools; Shielding Cohort; Street Support Improvement Board; Volunteering; PPE; Testing; Primary Care; Discharge; Palliative Care; Data; Support to Care Homes; Contact Tracing and Outbreak Control.

- Other sections include the approach to risk management during the crisis and governance. Given the significance of the financial implications, both additional costs and lost income, there is a separate report on the agenda outlining the latest position and the issues.

- Some examples, since the last report, of activity and impact across the city are as follows and are depicted in an infographic at the end of this section:
    - 190,000 visits to dedicated webpage at www.leeds.gov.uk/coronavirus
    - 11,000 calls for support answered by two helplines

- Launch of a new welfare calls service, 'Are U OK?, providing welfare check-in calls to those that request it through the COVID-19 helpline
- 18,000 clinically shielded people contacted.16,099 of this cohort have also registered nationally.
- 8.6 million items of PPE (including gloves, aprons and masks), plus 13,911 bottles of hand sanitiser and 37,677 clinical waste bags delivered to almost 500 care homes, children's homes, doctor's surgeries and hospices
- An additional 1,472 packages of support provided to people, either in their own homes or in a care home since the beginning of March.
- £130,805,000 in grants paid to 10,598 businesses
- 10,000+ food parcels delivered and more supported locally through volunteer-assisted shopping
- 330,000 leaflets posted to households with information about accessing support. This has been translated into 12 community languages.
- 52% reduction in air pollution (nitrogen dioxide) across the city compared to last year
- 21,590 children provided with Free School Meals through schools and local hubs across Leeds every week. This comprises 7,090 Grab Bags, 2,700 Hampers, (which is the equivalent of 13,500 meals), plus a further 1,000 hot meals.
- 25% increase in Meals at Home service, providing 800 meals per day, 7 days a week.
- 3.2 million black and green bins collected since lockdown began, with waste 15% higher than usual. Household Waste Recycling Centres re-opened from 11 May on a booking system basis, with 19,600 slots available to book each week
- 33 volunteer coordinator hubs established across the city, supported by 5,200 volunteers. Between 24 March and 28 April 5629 referrals were made to the volunteer hubs.
- 33 Facebook pages set up, one for each ward of the city, to share updates and information
- 129,000 views of online learning videos posted on YouTube by the museums and galleries service, a 30% increase since 23 March
- 4,887 duty of care calls have been made to vulnerable Leeds Card members in 3 weeks
- 133 exercise videos have been added to the Active Leeds YouTube channel, with almost 17,000 views
- 21,746 people visited the new Active Leeds Healthy at Home website
- 753,445 people reached through the Active Leeds Facebook page
- 7000+ essential housing repairs and 4,300 gas safety checks undertaken
- 215 people provided with emergency accommodation
- Over 700 vulnerable Leeds residents from a cohort of 1700 clinically high risk tenants contacted in one week by the Housing Strategy & Investment team. These calls have resulted in referrals for food parcels, urgent welfare advice and safeguarding.
- 630 people per week assisted over the telephone by Leeds Housing Options, achieving a positive accommodation outcome for 90% of people who approach the Council when threatened with homelessness.
- Over 7000 Council tenants over 70 contacted by Housing Leeds to check their wellbeing, with over 200 referred to foodbanks or additional support. Weekly contact being maintained with over 600 tenants.
- Housing Leeds are operating an emergency amendment to the lettings policy, a lettings panel has been established to rehouse customers who fall into specific priority groups, including hospital discharge cases, high risk cases of domestic violence and abuse, and those in supported/temporary accommodation who are tenancy ready. The panel are working collaboratively with housing association partners and to date have rehoused 26 customers in urgent housing need- two of these cases were rehoused in RSL accommodation.

# Coronavirus – summary of council impact

(May 2020)

Leeds CITY COUNCIL

**11,000**
**calls**
for support answered by two helplines

**8.6million**
**items of PPE**
delivered to almost 500 care homes, children's homes, doctor's surgeries and hospices

**£130m+**
**in grants**
have been paid to 10,598 businesses up to 15 May

**10,000+**
**food parcels**
delivered and more supported locally through volunteer-assisted shopping

**52%**
**reduction**
in air pollution (nitrogen dioxide) across the city compared to last year

**3.2million**
**black/green bins**
collected since lockdown began, with waste 15% higher than usual

**5,200**
**active volunteers**
supporting the most vulnerable residents through 33 volunteer hubs

**7,000+**
**essential**
housing repairs and 4,300 gas safety checks undertaken

**19,600**
**slots**
available to book each week to use Household Waste Recycling Centres since they re-opened on 11 May

**17,000**
**views**
of 133 exercise videos uploaded to the Active Leeds YouTube channel

**1,472**
**additional**
packages of support to people, either in their own homes or in a care home

**21,590**
**children**
provided with free school meals through schools and local hubs across Leeds every week

## 2. Best Council Plan Implications (click here for the latest version of the Best Council Plan)

- In terms of the Best Council Plan, adaptations are being made to the version that was agreed at February Full Council to ensure that the COVID-19 context is accurately captured – this will be published soon. We plan a further, more fundamental review of the suite of city strategies later in the year when we know more.

## 3. Resource Implications

- Given the significance of the financial implications of coronavirus, there is a separate and more detailed report included on the agenda for this meeting, so the details are not repeated here.

## 4. Recommendations

Executive Board is requested to:

1) Note the updated national context and local response to the coronavirus (COVID-19) outbreak.
2) Agree the updated Response and Recovery plan update, including the updated aims and objectives.
3) Agree the approach and messaging for running a safe city.
4) Use this paper as context for the more detailed paper on the financial implications of coronavirus for the council

## 1. Purpose of this report

1.1 This report updates Executive Board on the coronavirus (COVID-19) work across the city, being driven by the response and recovery plan previously reported to Executive Board in March and April. This plan aims to mitigate the effects of the outbreak on those in the city, especially the most vulnerable, and prepare for the early stages of recovery. The city's multi-agency command and control arrangements are set within the national approach and guidance from the government, plus the context of resilience and health partnership arrangements at a West Yorkshire level, and the Combined Authority. This paper covers organisational issues arising from the pandemic as well as a citywide update.

## 2. Background information

2.1 Since the outbreak of the coronavirus in December 2019, the number of cases recorded across the world continues to increase, including the United Kingdom. The government has taken a significant number of further measures in response to the outbreak which have been described in the March and April coronavirus Executive Board reports. Since the government's decision on 16 April that the measures of lockdown restrictions, must remain in place for at least 3 weeks, there have been a range of further key developments in the national response to the coronavirus outbreak including the publication of a recovery strategy which sets out the plans for moving to the next phase of the UK response to the virus. This report does not detail every national development, but covers some of the most significant. Full details of guidance and communications issued by the government can be found on the gov.uk website.

2.2 On 16 April, the government outlined five specific tests to be satisfied in order to determine a safe adjustment of the current measures and easing of the lockdown:

- Confidence that the NHS will be able to provide sufficient critical care and specialist treatment right across the UK
- A sustained and consistent fall in the daily death rates from coronavirus
- Reliable data from SAGE demonstrating that the rate of infection is decreasing to manageable levels across the board.
- Confidence in testing capacity and PPE - supply able to meet future demand.
- Confidence that any adjustments to current measures will not risk a second peak of infections that overwhelms the NHS.

2.3 The government has made several announcements on testing since the last update to the Executive Board. On 17 April the government announced access to testing for individuals with symptoms of coronavirus will be extended across England to include further frontline workers and symptomatic members of their family or household to allow the key worker to return to work. The full list of eligible workers included; all NHS and social care staff; police, fire and rescue services and local authority staff such as those working with vulnerable children, adults and victims of domestic abuse, and those working with the homeless and rough sleepers. A further announcement in relation to testing by the Department for Health and Social Care (DHSC) on 23 April confirmed all essential workers in England, and members of their households who are showing symptoms of coronavirus will now be able to get tested. A wide range of testing methods would be rolled-out to increase accessibility, including home testing kits, mobile testing sites and satellite testing kits. Moreover, the government also announced on 26 April that essential workers and the most vulnerable will gain increased access to coronavirus tests with network of mobile testing units (operated by the Armed Forces) will travel where there is significant demand, including care homes, police stations and prisons. A further expansion of access to coronavirus testing was announced on 28 April, where anyone in England with symptoms of coronavirus who has to leave home to go to work, and all symptomatic members of the public aged 65 and over, will now be able to get tested. Additionally, a major home testing programme for coronavirus which will track levels of infection in the community was detailed on 29 April, where a 100,000 people will be sent self-testing kits to determine if they are currently infected. More recently, the Secretary of State for Housing, Communities and Local Government, Robert Jenrick MP wrote to all councils in England on 1 May, reminding them of their eligibility for testing.

2.4 The Local Government Minister Simon Clarke MP also wrote to all councils in England on 17 April to work with faith groups and funeral directors to develop safe, sensitive and innovative ways for funerals to take place. The statutory guidance for local authorities in England on Schedule 28 to the Coronavirus Act was also published, which provides powers to support local and national death management. Further guidance on the management and organisation of funerals during the coronavirus pandemic was issued by Public Health England on 19 April, which details the exceptions which can be made to restriction advice currently in place to allow families and friends to attend funerals, including those who are self-isolating or who have been defined as extremely clinically vulnerable, should they wish to.

2.5 On 18 April, the government announced further funding to councils across England of £1.6 billion, to support in dealing with the immediate impacts of coronavirus. Council allocations from this specific funding was announced on 28 April with Leeds receiving £21.7m as part of it second tranche of COVID-19 funding. The first

tranche of support grant funding for Leeds was £22m (£21,964,950), although the methodology used for the second tranche was an allocation per head of population. This is covered further in the finance report on the agenda.

2.6 On 20 April, the government's Coronavirus Job Retention Scheme was open for applications allowing employers to claim for a cash grant of up to 80% of a furloughed employees wages, capped at £2,500 a month. Employers can apply for direct grants through HMRC's online portal. The government further announced details of the grant funding provided to businesses by councils in England, publishing data on the amount of money distributed to SMEs by every local authority in England as part of the grant schemes launched to support businesses with the impact of coronavirus. The Chancellor of the Exchequer also announced a £1.25 billion government support package which aims to support UK businesses driving innovation and development during the coronavirus outbreak. The package includes a £500 million investment fund for high-growth companies impacted sourced from funding from the government and the private sector. SMEs focusing on research and development will also have access to £750 million of grants and loans.

2.7 The Chancellor outlined additional details of the government's Coronavirus Large Business Interruption Loans Scheme (CLBILS) on 21 April. Companies with a turnover of more than £45 million will now be able to apply for up to £25 million of finance, and up to £50 million for firms with a turnover of more than £250 million.

2.8 On 22 April, the Ministry of Housing, Communities and Local Government (MHCLG) wrote to local authority chief executives in England about extending the statutory audit deadlines for 2019 to 2020. The publication date for final, audited, accounts will move from 31 July for Category 1 authorities and 30 September for Category 2 authorities to 30 November 2020 for all local authority bodies.

2.9 On 23 April, the government made a series of announcements. The Department for Health and Social Care (DHSC) announced the start of a virus infection and antibody test study. The study aims to improve understanding of the current rate of infection and how many people are likely to have developed antibodies to the virus. 20,000 households in England are being contacted to take part in the first wave of this study. The Local Government Minister Simon Clarke MP also wrote to Leaders of local authorities in England, in relation to continued access to parks and public spaces including burial grounds and cemeteries. Additionally, the Department for Education (DfE) further announced greater flexibility to councils to move free entitlements funding between settings in exceptional cases to meet demand during the outbreak. Councils will temporarily be able to use the funding they receive for the free entitlements for two, three and four-year-olds differently, redistributing it where particularly necessary to support critical workers and the parents of the most vulnerable children, when their usual arrangements are no longer possible as a result of coronavirus.

2.10 On 24 April, the government announced furloughed workers will receive full parental leave entitlement. Furloughed workers planning to take paid parental or adoption leave will be calculated based on usual earnings rather than furlough pay rate. Full earnings will apply to Maternity Pay, Paternity Pay, Shared Parental Pay, Parental Bereavement Pay and Adoption Pay.

2.11 On 27 April, the government published new guidance for social landlords on essential moves with councils and housing associations asked to continue to support vulnerable people to move home. The guidance states that all social landlords should prioritise essential moves and do what they can to ensure these can take place, when safe to do so. Essential moves include, supporting victims of domestic abuse and people fleeing violence as well as supporting discharge from hospital to free-up bed space for others requiring care.

2.12 The Chancellor also announced a new 100% government Bounce Back Loans scheme for small business on 27 April. Businesses can borrow between £2,000 and £50,000 and loans will be interest free for the first 12 months with businesses able to apply via an online form. The scheme launched on 4 May. The scheme will offer smaller amounts than the existing Coronavirus Business Interruption Loan Scheme (CBILS) and should be quicker and easier to apply for. The loan is 100% guaranteed by the government with an interest rate of 2.5% and the loans will last up to six years with funds made available quickly. Businesses who have applied for a CBILS loan of £50,000 or less will be able to switch to a BBLS loan should they choose to, or to convert an existing CBILS loans to a BBLS loan.

2.13 On 29 April, NHS England and NHS Improvement (NHSEI) chief executive Sir Simon Stevens and Chief Operating Officer Amanda Pritchard wrote to NHS organisations across the country to outline a second phase of the response to COVID-19. This letter also highlighted that given the scale of the challenges, NHS organisations must also continue to partner with local authorities and Local Resilience Forums (LRFs) in providing mutual aid with colleagues in social care, including care homes.

2.14 On 30 April, the Communities Minister, Lord Greenhalgh wrote to local authority chief executives highlighting that some members of Gypsy and Traveller communities are likely to be particularly vulnerable to COVID-19, and may need support in accessing basic facilities in order to enable them to adhere to public health guidelines around self-isolation and social distancing during the outbreak.

2.15 On 1 May, the Ministry of Housing, Communities & Local Government (MHCLG) announced that Business Improvement Districts (BIDs) will receive £6.1m funding in response to the coronavirus pandemic. These monies will be distributed via a grant to local authorities to be passed on to BIDs, and will cover funding for 3 months and contribute to their operational costs.

2.16 NHSEI wrote to GP practices and primary care networks, CEOs of community health providers, regional directors of primary care and CCG accountable officers on 1 May requesting that primary care and community health services further support care homes, building on what practices are already doing.

2.17 On 2 May, the government announced the Local Authority Discretionary Fund of up to £617 million to accommodate specific small businesses previously outside the scope of the business grant funds scheme. This is an additional 5% uplift to the £12.33 billion funding previously announced for the Small Business Grants Fund (SBGF) and the Retail, Hospitality and Leisure Grants Fund (RHLGF). The exact amount allocated for each local authority is yet to be announced and the scheme is not yet open for applications. The latest advice is that should there be any remaining funding from initial SBGF and RHLGF allocations (having made payments to all eligible businesses) the remaining funding would need to be used

first in the discretionary scheme, and additional funding would only be made available where there are insufficient remaining funds to meet the costs of the additional 5% discretionary grant fund. However, the council is able to launch the new Local Authority Discretionary Fund scheme prior to existing grant funds from the initial scheme having been exhausted. Early indications suggest that this new additional fund is aimed at small businesses of under 50 employees, and local authorities will be asked to prioritise small businesses in shared offices or other flexible workspaces such as in industrial parks, science parks and incubators which do not have their own business rates assessment; regular market traders who do not have their own business rates assessment; Bed & Breakfasts which pay Council Tax instead of business rates; and charity properties in receipt of charitable business rates relief which would otherwise have been eligible for Small Business Rates Relief or Rural Rate Relief. However, local authorities will be given flexibility to make payments to other businesses based on local economic need, and how funding is allocated will be at the discretion of local authorities. The maximum grant will be £25,000. Local authorities will be given discretion to make payments of any amount under £10,000. Further government guidance for local authorities has very recently been published and the council will develop and establish the necessary processes for effective local implementation.

2.18 The government also announced £76 million of extra funding for charities to support survivors of domestic abuse, sexual violence and vulnerable children and their families and victims of modern slavery. It was further announced on 2 May that a specialist taskforce has also been created to lead the next phase of the government's support for vulnerable rough sleepers during the pandemic. Led by Dame Louise Casey, the team of experts will advise councils on plans to support rough sleepers into long-term, safe accommodation once lockdown is lifted.

2.19 On 4 May, the government announced that Isle of Wight residents will be the first to get access to a new 'test, track and trace' programme. Rollout of the NHS COVID-19 App will begin with the island's NHS and council staff.

2.20 Since the 4th May, HMRC has contacted potential customers who may be eligible for the Self-employment Income Support Scheme that will allow the self-employed to claim a taxable grant worth 80% of their trading profits up to a maximum of £2,500 per month for the next three months. This may be extended if needed and opened on the 13 May with payments backdated to 20th March.

2.21 On 5 May, Ofqual published its initial consultation decisions on who should receive a calculated grade for GCSEs, AS and A levels. In terms of the calculated grades for students in year 10 and below, Ofqual have decided that these students will be eligible to receive calculated grades this summer. Ofqual is expected to publish the final decisions later in May, in relation to the other specific proposals for awarding GCSEs, AS/A levels, Extended Project Qualification and Advanced Extension Award in maths this summer.

2.22 The Local Government Minister Simon Clarke MP and Environment Minister Rebecca Pow MP also wrote to councils on 5 May on the re-opening of household waste and recycling centres. The letter further highlights additional guidance published by the Department for Environment, Food and Rural Affairs (DEFRA) to support councils in maintaining access to key facilities and, where necessary, with managing the process of re-opening.

2.23 On 6 May, the government announced the launch of a new dedicated app for the adult social care workforce in England to support staff through the coronavirus pandemic. Care workers will get access to guidance, learning resources, discounts and support will be offered on mental health and wellbeing through toolkits.

2.24 On 9 May, the government announced a £2 billion package which seeks to create alternative ways to travel, such as walking and cycling, which could relieve the pressure on public transport. The investment seeks to create emergency bike lanes and streets that will help support the transport network, trials of rental e-scooters to be brought forward to increase green transport options and the government will work with tech developers to reduce crowding on public transport. Pop-up bike lanes with protected space for cycling, wider pavements, safer junctions, and cycle and bus-only corridors will also be created in England as part of a £250 million emergency active travel fund - the first stage of a £2 billion investment, as part of the £5 billion in new funding announced for cycling and buses in February.

2.25 On 10 May, in his address to the nation, the Prime Minister announced details of a "conditional plan" for easing the lockdown measures enacted on 26 March and extended on 16 April and 7 May. Updating national messaging now calls on the public to *Stay Alert: Control the Virus: Save Lives.* The government has further stated the easing of some measures will occur in three phases, dependent on the spread of the virus. Details of the government's approach were further published in a range of new guidance and the UK Government's COVID-19 recovery strategy on 11 May. The government's recovery strategy sets out the plans for moving to the next phase of its response to the virus and a roadmap to easing existing measures in a safe way, subject to controlling the virus and being able to monitor and react to its spread. A summary of the three steps included in the strategy and the set ambitions in each phase is below:

- **Step one** changes will apply from 13 May in England.
  - This includes guidance that workers should continue to work from home rather than their workplace, wherever possible. All workers who cannot work from home should travel to work if their workplace is open.
  - Sectors of the economy that are identified as allowed to be open include food production, construction, manufacturing, logistics, distribution and scientific research in laboratories.
  - Exceptions to this are those workplaces such as hospitality and nonessential retail which are required to remain closed.
  - Guidance is maintained in relation to those who have symptoms, however mild, or are in a household where someone has symptoms i.e. they should not leave their house to go to work and self-isolate, including those in their households.
  - In relation to vulnerable children, or the children of critical workers, attending school: LAs and schools are advised to continue to urge more children who would benefit from attending in person to do so.
  - Travel: When travelling everybody (including critical workers) should continue to avoid public transport wherever possible. Social distancing guidance on public transport must be followed rigorously.
  - Face coverings: the government is now advising that people should aim to wear a face-covering in enclosed spaces where social distancing is not always possible and they come into contact with others that they do not normally meet, e.g. on public transport or in some shops.
  - People can now also spend time outdoors subject to various conditions i.e. not meeting up with any more than one person from outside your household;

continued compliance with social distancing guidelines to remain two metres apart from individuals outside your household; maintaining good hand hygiene, and those responsible for public places being able to put appropriate measures in place to follow the new COVID-19 Secure guidance.
    - People may also exercise outside as many times each day as they wish. However individuals will still not be able to use playgrounds, outdoor gyms or ticketed outdoor leisure venues. People can only exercise with up to one person from outside their household.
    - People may drive to outdoor open spaces regardless of distance, so long as they maintain social distancing guidance.
    - Those who are more clinically vulnerable to coronavirus such as those aged over 70, those with specific chronic pre-existing conditions and pregnant women should continue to take particular care to minimise contact with others outside their households.
    - Those in the clinically extremely vulnerable group (shielding group) are strongly advised to stay at home at all times and avoid any face-to-face contact.

- **Step two**: the government's current aim is that this step will be made no earlier than 1 June, however, the timing of the second stage of adjustments will primarily depend on the most up-to-date assessment of the risk posed by the virus. The current planning assumption for England is that this step may include some of the following measures as possible:
    - A phased return for early years settings and schools with preparations to begin to open for more children from 1 June. Government expectations include children to be able to return to early years settings, and for Reception, Year 1 and Year 6 to be back in school in smaller sizes, from this point. This phases also aims for secondary schools and further education colleges should prepare to begin some face to face contact with Year 10 and 12 pupils who have key exams next year, in support of their continued remote, home learning. The Government's set ambition is for all primary school children to return to school before the summer for a month if possible, though this will be kept under review.
    - Opening non-essential retail when and where it is safe to do so, and subject to those retailers being able to follow the new COVID-19 Secure guidelines.
    - Permitting cultural and sporting events to take place behind closed-doors for broadcast, while avoiding the risk of large-scale social contact.
    - Re-opening more local public transport in urban areas, subject to strict measures to limit as far as possible the risk of infection in these normally crowded spaces.

- **Step three:** The government's current planning assumption is that this step will be no earlier than 4 July and will be subject to the five tests outlined and will take place when the assessment of risk permits further adjustments to the remaining measures.
    - The set ambition for this phase is to open some of the remaining businesses and premises that have been required to close, including hairdressers, hospitality, places of worship and leisure facilities (like cinemas). They should also meet the COVID-19 Secure guidelines.

2.26 The Prime Minister also announced the establishment of a new COVID-19 Alert system in order to monitor infection rates and the impact of any changes to the lockdown. The system will be run by a new Joint Biosecurity Centre (JBC) which will provide real time analysis and assessment of outbreaks at a community level, which will enable rapid intervention. The Centre will also advise on the general prevalence

of COVID-19 to help inform decisions to ease restrictions in a safe way. The alert levels are:

- **Level 1:** COVID-19 is not known to be present in the UK
- **Level 2**: COVID-19 is present in the UK, but the number of cases and transmission is low
- **Level 3**: A COVID-19 epidemic is in general circulation
- **Level 4:** A COVID-19 epidemic is in general circulation; transmission is high or rising exponentially
- **Level 5**: As level 4 and there is a material risk of healthcare services being overwhelmed

2.27 Following the initial steps outlined by the Prime Minister in relation to the recovery strategy, the government has also published new guidance for employers on 11 May, setting out practical guidelines to ensure workplaces are as safe as possible. The new guidance covers 8 workplace settings which are permitted to be open, from construction sites to takeaways. Up to an extra £14 million has also been made available for the Health and Safety Executive (HSE) for extra call centre employees, inspectors and equipment.

2.28 The government also launched a new online portal on 11 May, which seeks to make it easier for care homes to arrange deliveries of coronavirus test kits. All symptomatic and asymptomatic care home staff and residents in England are eligible for testing. Moreover, testing will be prioritised for care homes that look after the over 65s.

2.29 On 12 May, the Chancellor confirmed the extension of the government's Coronavirus Job Retention Scheme until the end of October. Furloughed workers across UK will continue to receive 80% of their current salary, up to £2,500. The scheme is expected to continue in its current form until the end of July, with greater flexibility worked in to the system from the start of August to support the transition back to work. More specific details of its implementation are expected to be made available by the end of this month.

2.30 On 13 May, the government announced that five new ministerial-led taskforces have been established to plan how closed sectors can reopen safely. These are:

- pubs and restaurants (Department for Business, Energy and industrial Strategy)
- non-essential retail (including salons) (Department for Business, Energy and industrial Strategy)
- recreation and leisure, including tourism, culture and heritage, libraries, entertainment and sport (Department for Culture, Media and Sport)
- places of worship, including faith, community and public buildings (Ministry for Housing, Communities and Local Government)
- international aviation, reflecting the unique challenges that sector is facing (Department for Transport)

2.31 The Prime Minister also announced on 13 May a further £600m of funding for local councils, focused on adult social care and COVID-19 pressures in care homes.

2.32 Since the announcement of the government's recovery approach, a series of new guidance has been published such as; for owners and operators of urban centres and green spaces to help social distancing; details on a range of outdoor activities which

will be allowed in England from 13 May 2020 subject to social distancing rules; and guidance on the closure of certain businesses and venues as part of further social distancing measures.

2.33 The number of COVID-19 cases are being updated daily on the .gov.uk website COVID-19 cases by local authority. Across the UK as of 14 May there are 233,151 confirmed cases with 33,614 deaths. Leeds has 1,678 confirmed cases and 525 deaths as of 14 May.

2.34 As reported to Executive Board in April, in addition to the nationally reported data which covers deaths in settings where there has been a positive COVID-19 test result, the Office for National Statistics (ONS) also report on death registrations where COVID-19 has been identified as the cause of death or a contributing factor to the cause of death. ONS also publish excess deaths data comparing deaths in 2020 with previous year deaths and rolling averages over five years. The COVID-19 death data published by ONS is based upon the cause of death indicated on the death certificate rather than all of those deaths being confirmed with the benefit of a COVID-19 test.

2.35 In relation to Leeds specific data, all deaths registered in the period 27 March to 14 May 2020, there were 525 deaths which were identified as relating to COVID-19. In regard to where those people died, 296 (56%) died in a hospital setting, 200 (38%) died in care homes and 29 (6%) died in a hospice or at home. Of all deaths registered since the 27 March 2020 when we received the first suspected COVID-19 related death registration, 33% of all deaths registered have been identified as COVID-19 related.

2.36 Excess deaths through comparison to the equivalent week in 2019 saw for the w/e 3 April an 84% increase in death registrations, w/e 10 April a 52% increase, w/e 17 April a 124% increase, w/e 27/4 a 114% increase, w/e 1/5 a 87% increase and for w/e 8/5 a 57% increase. The excess death data will need to be tracked over a longer period to assess the full extent of excess deaths in 2020.

2.37 As the number of death registrations can vary from day to day, we have also analysed figures on a rolling 7-day basis. At its peak on the 20th April, the rolling average was 18.7 COVID-19 registrations per day which had reduced to 13.29 per day by the 30th April. This rolling average as well as the excess death data above suggests Leeds is over the peak and is now starting to see a steady reduction in COVID-19 death registrations.

## 3. Main issues

### 3.1 Planning, delivery and governance

3.2 Details of the multi-agency command and control arrangements for the outbreak in Leeds were described in the April 2020 Executive Board report set alongside the wider governance and delivery framework at a sub-regional level including the West Yorkshire Local Resilience Forum strategy. The partnership focus in the response phase has been in mitigating and reducing the immediate impact of the outbreak, particularly for the most vulnerable; maintaining business continuity of key services; and, providing what support we can to individuals, families and communities; and those businesses affected. This approach has been effective with the resources and information available, but as the council prepares to transition into the recovery phase it is vital that this continues to be driven by data as well as being informed by

a clear engagement plan with the public as they will ultimately determine the successful delivery of this next phase. The importance of local engagement with national systems cannot be emphasised enough.

3.3 The multi-agency arrangements have been further developed since the last Executive Board paper to be appropriate for the circumstances and are attached as part of the response and recovery plan, with the main focus of these being about the best possible coordination and communications to handle this complex and rapidly developing global challenge. The main changes have been in the Health and Social Care area, where groups have been rationalised to provide clearer accountability and focus for this phase, with an additional Silver and Bronze group for care homes given the focus. Additionally, the number and focus of bronze groups has developed to reflect the changing nature of the challenge, with new groups during this period for example on returning to public spaces and returning schools.

3.4 The West Yorkshire Resilience Forum (WYLRF) has agreed a refreshed strategy (attached at annex A) which focused more on recovery, with all five councils heavily involved to ensure fit with local approaches. Daily Strategic Coordinating Group (SCG) calls during this period. Daily Sitreps have been submitted to WYLRF raising issues and providing an updated position on key issues. Summaries of the issues being raised have been included each week in one of the updates to councillors and MPs and checked with the Leeds Gold SCG. The Leeds sitrep has stayed at an Amber rating throughout this period and an example of issues raised in one of this week's daily sit reps is as follows to give an illustrative flavour of the reporting to the LRF:

- Reset / recovery - resuming key services remains a big issue within each organisation and across the city and beyond will be a significant challenge not to mention public confidence and trust etc. Working through the guidance.
- Testing – some issues about delayed test results reported from care homes (from home tests). Some mixed messages about MTU/Temple Green capacity.
- PPE - ongoing concerns about supply despite local and national efforts, still feels hand to mouth across all areas. Very concerned about move to a complete national supply system, with clear preference for the work done in WY (NHS, WYCA, councils etc.) to be progressed. Specific issue over the weekend with some face masks, causing additional concern. Appears that LRF supplies getting smaller.
- Care Homes - continued concerns about care homes, with high number of suspected or confirmed outbreaks, but continued extensive support from infection control team and on PPE. New action plan in place and specific bronze group to ensure support.
- Financial impact – ongoing concerns about massive impact on council finances and other bodies. Most councils considering whether a S114 might be required in the coming weeks.
- Inequalities remain a significant concern – short and medium and long term – health aspects, economic, social aspects, disproportionate effect e.g. rough sleepers, vulnerable children, DV etc.
- Food – ongoing concerns about challenge to maintain food supplies for the most vulnerable with demand increasing significantly and period of supply looking longer, plus concerns about national supply to shielded remain
- Shielding - resolving outstanding issues on shielding to ensure everyone gets what they need – lack of clarity on a few things – data, food, NHS volunteers etc.

Concerns about numbers increasing and time period that shielding support will last for.

3.5 The WYLRF chair has provided periodic updates to MPs and leaders of WY councils, their website is up and running and there has been some media coverage of the role of the LRF.

3.6 Additionally, there has been significant liaison across the West Yorkshire councils (through Leader and Chief Executive groups) to ensure consistency on key issues, such as the way funerals are conducted, the way business grants are re administered, and the re-opening of key services such as Household Waste and Recycling sites. At a Yorkshire and Humber level, liaison between the 22 councils and 4 LRFs (Humberside, North Yorkshire, South Yorkshire and West Yorkshire) continues to support and ensure coordination where required, consistency of approach where relevant, resource issues share best practice and influence national developments.

3.7 The Yorkshire and Humber regional chief executive link to MHCLG and the Local Government Association (LGA) continues to remain an effective communication channel, engaging in regular calls with Whitehall colleagues and the eight other regional chief executives across England. The Chief Executive of Bradford Council currently represents the region in this group. This route is used to influence developments across government departments from a local government perspective, insofar as it is possible. The main focus of these discussions is about ensuring that national policy makes sense and works on the ground. Topics for discussion during this period have been about: local government finances, business grants, testing, tracking, tracing, shielded, and PPE. Leeds City Council has fulfilled its representative role on this group by maintaining strong links with councils across Yorkshire and Humber, regularly communicating to share information and gain feedback about relevant local issues related to coronavirus, whilst also continuing to share best practice and understand the picture across the region in the current context.

3.8 At the political level, the group of council leaders continue to have regular calls with the Secretary of State for Housing, Communities and Local Government and with the LGA, providing feedback about local impact in the current context.

3.9 On 12 May, it was announced that Leeds City Council's Chief Executive had been asked by the government to lead an important part of the contact tracing programme. This will be a temporary part-time arrangement for about 3 months, and will be done alongside the Chief Executive's role. The role is to represent the sector on this crucial issue to ensure that the testing and tracing arrangements work locally as part of broader local partnerships between councils, health and the voluntary sector, given their importance to successful and sustained easing of restrictions. The Chief Executive will continue to focus on the important issues for the council and the city, continuing to attend key local meetings. Directors will work with Executive Members, chief officers and their teams and with partners, to maintain the effective work underway.

3.10 An updated version of the **response and recovery plan** is attached at Annex B providing key headlines of activity and updates of the council and multi-agency partnership work. Regular updates to all councillors and MPs have continued, to provide information about the activity and impact in order that they can fulfil their role as ward members and elected representatives. The response and recovery plan has been continually reviewed and updated as the circumstances have developed, new

national guidance issued and further actions are identified or informed by data and intelligence in particular areas. Moreover, drawing on a range of data and analysis, a dashboard is produced weekly which provides a picture of activity across the city reflecting the themes of the response and recovery plan for the multi-agency Gold group. This week's dashboard is attached Annex C to illustrate the nature of data being considered. Many of the Silver and Bronze groups have specific data and intelligence reports produced to inform delivery activity.

3.11 As the nature of the pandemic changes, the phases of the response and recovery plan are developing towards recovery and renewal in some areas. The overarching aim and objectives of the Plan have been refreshed for this next phase, driven by our shared ambition and values, with the overriding priority of tackling poverty and inequalities consistent with our vision of a strong economy and a compassionate and caring city. It is however important to note that as we move into recovery in some areas and in order to get the city moving again, it is also apparent that other key areas will concurrently remain in response mode, for example mitigating any risks associated with the spread of the virus in care homes. As aspects of the council's governance restart with new virtual arrangements, we anticipate that scrutiny and corporate governance and audit will be involved. Community committees have been heavily engaged with the local arrangements to organise volunteering through the ward based arrangements.

3.12 The revised aim and objectives of the Leeds Response and Recovery Plan are as follows reflecting the ongoing transition:

***Aim:***

- The city's response and recovery will be driven by our shared ambition and values, with the overriding priority of tackling poverty and inequalities through a combination of a strong economy and a compassionate city.

***Objectives:***

- Continue to minimise the effect of the outbreak on the health and wellbeing of the city, especially the most vulnerable, and integrating services to achieve this;
- Ensure the provision of essential services, focusing on individuals, families, communities and businesses most affected, whilst encouraging communities to provide support themselves and be actively engaged in the part they can play;
- Work to resume economic and social activity safely and effectively with social distancing measures in place, in line with national guidance and advice;
- Begin to focus on recovery and renewal underpinned by our City Ambition's three pillars - Inclusive Growth, Health and Wellbeing and Climate Change.

3.13 The updated response and recovery plan maintains the framework as approved by Executive Board in March 2020, with a focus on six strands below. The sections later in this report provide a brief overview of the current position for each theme.

- Health and social care
- Infrastructure and supplies
- Business and economic impact
- Citizens and communities
- Organisational impact; and
- Media and communications

3.14 The complete process of recovery and the council's approach will be influenced by the guidance at national level from central government and informed by learning from others including partners. The various silver groups, and bronze task and finish groups highlighted in the April Executive Board paper, have been considering their priorities and challenges as we move to the next phase, including discussions with relevant Executive Members. The outcome of this continued work will be coordinated as national guidance becomes available, captured in the response and recovery plan and reported to Executive Board. Decisions about individual council services will be made in the normal way. Aspects of broader coordination, for example across health and social care or with the broader set of partners, will be progressed in line with normal governance routes.

3.15 The importance of learning lessons from incidents during this period will also be a key element of our planning ensuring that we maintain a good practice approach for all phases, with much of this being done informally, but a more formal lessons learned being planned at the right time and in the right way.

3.16 **Recovery phases and the immediate challenge of running a safe city**

3.17 The coronavirus outbreak has demanded a different approach to response and recovery given the unprecedented complexity and scale of the crisis. The various phases are likely to persist for long periods, are less well defined and are multifaceted with varying impacts on different parts of the population. This incident has a greater focus on a local authority lead throughout each phase compared to many other types of incident that see a shorter "blue light" led response phase and a quick handover into recovery. The council has focused its recent considerations on what recovery could look like in the city recognising the potential challenges and the opportunities of a renewed 'new normal' context, which seek to achieve longer term strategic goals. This approach will require that the council maintains its "place" leadership role continuing to work alongside communities, businesses and public services, convening conversations to resolve key issues and ensuring a collective endeavour.

3.18 Along with many others, and informed by learning and research, in broad terms, we can view the next phases as follows, with the first one being the primary focus of this month's report.

- **Responding to the virus and its effects, safely lifting lockdown**
- Living with the virus in the population, where social distancing has to be maintained
- A new normal, most likely once a vaccination is available

3.19 The entire process of recovery will be influenced by the central government recovery strategy where a phased return to normal in the city will be in line with the national approach. As outlined earlier in this report, the government strategy sets a three phase approach with staged adjustments to lockdown measures. Each phase gradually seeks to reopen society and kick start the economy and will therefore require careful management at a city level complementing the national guidelines and transition. We will also build on the shared learning from others to inform our approach to each phase and our aim is to clearly communicate our local approach recognising the wider factors and considerations at city level influenced by national developments. These include the impact on shielded and vulnerable groups; regular testing arrangements; ramping up contact tracing operations and being ready to

manage outbreaks; potentially switching on and off lock down measures; and gradual easements of lockdown measures.

3.20 Lifting lockdown safely and avoiding spread of the virus will be a huge challenge, where working together locally and nationally will be key. We will need the best ever coordination across the council and with other partners in the city to ensure that we build trust and confidence and don't put people at significant risk. We will need the public to play their part with handwashing and staying at home where possible, as well as being patient about services resuming. Effective communications and public engagement will be essential, whereas the "stay at home" messaging for lockdown was relatively straightforward, the messaging for lifting lockdown will be much more nuanced and subtle – not least because it will be different for different parts of the population, or potentially restrictions by geography.

3.21 We need to work with partners to find ways to run the city safely and effectively with social distancing measures in place, with an expectation that this transitional period may run for some time and with different impacts on different people. Depending on the effectiveness of the measures on infection rates, it may mean that more stringent lockdown measures have to be restarted, with services restarting and having to stop again. Running effective local arrangements for managing outbreaks, linked to the national tracing approach, will be key with clear plans and governance crucial. This will impact on public engagement, confidence and also on tolerance of the public. Linked to this is how the health and social care system gradually resumes services for the public both in the community and in hospitals. Clear communications will be vital. A one page infographic has been produced to support this approach (attached annex D).

3.22 Within the context of political leadership and governance, the multi-agency command and control arrangements have been discussing this issue, including new bronze groups for returning to public spaces and re-opening schools.

3.23 Whilst social distancing remains key for public health reasons, the overall framework that we are using to lift lockdown will be to use test, trace and outbreak management to build trust and confidence and to ensure:

- **Safe travel** ensuring the safe use of highways and public transport and encouraging active travel where possible.
- **Safe public spaces** with physical distancing in communities, district centres and the city centre.
- **Safe delivery of services** including health and social care, and other public services.
- **Safe education** as more children and young people return to schools, colleges and nurseries.
- **Safe working** with physical distancing in workplaces and coordination between large employers to avoid peaks of movement.

3.24 We will need everybody's continued cooperation to ensure restrictions can be eased safely, enabling us to support a strong public health response and strong economic recovery approach, delivering public services while continuing to protect and support vulnerable citizens. Clear communications during this next phase, to avoid a second peak, will be key. To complement the national messaging, our local messaging about a safe city will be as follows and illustrated in an infographic to help everyone understand:

- Stay at home if you can
- Maintain social distancing if you go out
- Wash your hands regularly and for 20 seconds
- Stay at home and isolate if you or anyone in your household has symptoms
- Limit contact with other people
- Work at home if you can
- Go to work if it is safe and you can maintain social distancing
- Only use public transport where necessary, and wear a face covering
- Continue to stay at home if you are shielded

3.25 In taking the positive opportunity from the pandemic and looking for improved ways of working, organisations and individuals are considering a number of key questions to guide the reset towards a new normal, plan system change, efficiency and transformation:

- What did we stop doing that should remain stopped?
- What did we stop doing that we should bring back?
- What have we started doing that we need to stop?
- What have we started that should continue?
- What are we not doing now that we have never done before, but that we might need?

3.26 Each silver group, and other bronze task and finish groups, have been considering these questions, their priorities and challenges as we move to the next phase, including discussions with relevant Executive Members. The outcome of this continued work will be coordinated as national guidance becomes available, captured in the response and recovery plan and reported to Executive Board. Decisions about individual council services will be made in the normal way. Aspects of broader coordination, for example across health and social care or with the wider set of partners, will be progressed in line with normal governance routes. The next section provides an update for each of the themes.

3.27 **Health and social care:**

3.28 Health and Social Care Gold command has been established to oversee the local management and system co-ordination of the pandemic. It encompasses all aspects of Leeds' local health and care system, chaired by the CCG Accountable Officer. It has a clear focus on ensuring hospitals have sufficient intensive care capacity whilst maintaining access for continuing, urgent and primary care and social care. Command arrangements include a range of regular silver and bronze groups.

3.29 The Bronze Groups have been rationalised as some have finished their tasks, and are now more appropriately called task groups. These groups are focusing on the priority areas that will continue to have an impact across the system.

- Care Homes
- Personal Protective Equipment
- Shielding
- Testing and Contract Tracing
- Frailty and End of Life
- Primary Care
- Impact on Provision of Healthcare Services and

- Stabilisation and Reset

3.30 There are also a wide range of both formal and informal boards and groups across the city that can escalate for decision to Gold or may be asked by Gold to resolve specific issues or make proposals to mitigate risks.

3.31 Health and Social Care continues with this command and control function as required at national and regional level as part of the Emergency Prevention, Preparedness and Response (EPPR) approach, but locally the focus is shifting firmly forward into living with COVID-19 phase. As such, going forward, there will be a need to strike the balance between:

- Stabilisation and resetting
- Re-opening services in a safe and co-ordinated way, at the appropriate time
- Planning for potential further COVID-19 and winter surges

3.32 Healthwatch (HWL) has also had an active role in Leeds' Command arrangements in response to the COVID-19 pandemic and is represented in the Health and Care Gold Command arrangements. Since early April 2020, HWL has been running a COVID-19 listening campaign; producing a weekly report with insight into how it is feeling for people – particularly those communities in Leeds with the greatest health inequalities. As part of the overall campaign, Healthwatch Leeds has been running a 'Question of the fortnight' focusing on a range of service issues, including:

- The move to digital service provision;
- People's mental health and access to mental health services; and,
- Information about COVID-19 provision.

3.33 The insight derived from this activity is designed to be used by decision makers and feeds in directly to Health and Care Gold Command.

3.34 **Personal Protective Equipment**

3.35 Personal Protective Equipment (PPE) remains a serious concern across the city's health and social care system. The local health and care system continues to have issues with the availability and quality of some PPE. The Local Resilience Forum emergency drops remain important until the new supply chain is operational; and close monitoring for any increases in demand from other areas increases will also be taking place, in light of the government's easing of some lock down restrictions.

3.36 Significant work has been undertaken across the system to ensure that those staff that need PPE have access to it. Systems for sourcing and distribution are in place, drawing on WYLRF and locally procured stock. Extensive work on the application of the Public Health England national guidance has been undertaken by DPHs across West Yorkshire and beyond. A local position statement based on national guidance was developed and agreed on April 14th 2020. However, further guidance has since been released by Public Health England, that covers domiciliary care and care homes. The local position statement is subsequently in the process of being revised by Public Health in line with this new national guidance and is due to be signed off imminently.

3.37 Public Health officers, along with wider colleagues in the Adults and Health directorate, have also developed draft PPE guidance for the LCC/Voluntary Action Leeds volunteer schemes.

3.38 **Testing**

3.39 The national COVID-19 testing programme is being rolled out across the city, under the leadership of the Director of Public Health. The Leeds testing site at Temple Green has successfully increased its capacity, which now stands at 1,000 slots per day. Eligibility criteria for testing has also been expanded from health and social care staff only, to include over 65s, and care home staff / residents with or without symptoms. Local colleagues have been pushing for additional capacity, including for mobile testing units, with local members being kept informed of developments as far as possible given this is a DHCS/military operation.

3.40 A national booking system is in place for employers and /or staff to book a test or to order home testing kits. Ongoing discussions are taking place around potential sites for temporary mobile test units in addition to the Temple Green site. Local colleagues are also able to access the testing at LTHT with extensive liaison through a testing group to ensure local prioritisation as far as possible within the national framework.

3.41 In addition, and as mentioned the government recently announced a major new programme of home testing for COVID-19 that will track the progress of the infection across England. The programme will help improve understanding of how many people are currently infected with the virus, and potentially how many have been infected and recovered since the outbreak began. In the first part of the programme, 100,000 randomly selected people from 315 local authorities across England will be invited to provide nose and throat swabs, which will be tested for antigens indicating the presence of the virus. In the second part of the programme, a number of different antibody tests will be assessed for their accuracy and ease of use at home. If antibody self-testing is found to work with a high degree of accuracy, acceptability and usability, it will be rolled out to 100,000 people later in 2020, to provide an indication of the prevalence of coronavirus based on the presence of coronavirus antibodies.

3.42 **Care Homes**

3.43 A detailed action plan has been developed focusing on the overall support for care homes, against the following objectives

- Objective 1: To minimise infection and mortality levels across our care homes and supported living schemes
- Objective 2: Support the well-being of care home residents
- Objective 3: Support the well-being of care home staff
- Objective 4: Ensure safe admission to care homes
- Objective 5: To respond in a timely way to care homes experiencing difficulties
- Objective 6: Support care homes with simple and timely information

3.44 Care Homes have remained a continued focus of the council's and wider health and care system's response throughout the pandemic – with a number of suspected and confirmed outbreaks. This number is highly variable but being reported regularly to command and control groups and to MPs/councillors. There is continued extensive support from the infection control team and around the availability of PPE. Combined with new discharge protocols, extended testing for care homes from LTHT is proving to be very useful – building on the community testing in care homes had throughout the pandemic.

3.45 On 7 May, the Minister of State for Care wrote to those involved in delivering social care; setting out further information on COVID-19 testing in care homes. The letter asks Local Directors of Public Health to lead work with Directors of Adult Social Services, local NHS providers, and PHE Regional Directors to ensure that testing of staff and residents in care settings is more joined up, and that available national capacity is targeted to areas and care homes with the greatest need. There has been one uplift to Care Homes, with further work underway to understand the financial impact and provide support where possible.

3.46 As part of this, a new web portal is also being set up by the Department of Health and Social Care – with the aim of making the arrangement of tests for care homes as easy as possible; and will enable all care home residents and staff to be tested at the same time.

3.47 The portal will only be accessed by those needing to order testing for care home staff and residents; and details of this process and how testing can be accessed will be shared with care home providers as soon as this becomes available.

3.48 Along with care providers, local authorities are being asked to support care homes as they receive the results of those tests and support the prioritisation of testing through this route. This is likely to include:

- Identification of all eligible care homes
- Referral of homes for testing via the portal (or supporting the care home referring themselves)
- Provision of local contacts and support information for each home

3.49 Following the processing of laboratory tests, results for residents will be communicated to care home managers and shared with local councils in order to help manage COVID-19 outbreaks in local areas.

3.50 A testing group has been established which links colleagues from across the health and social care system to ensure effective pathways to testing; and early discussions are under way to ensure that the national contact tracing programme works for Leeds and delivers for the local system. Leeds has a strong record of effective outbreak planning and response across the health and care system, which puts the city in a strong position to take this work forward.

3.51 **Leeds Teaching Hospitals NHS Trust (LTHT)**

3.52 Following the declaration of a Level 4 national incident on 30 January 2020, in mid-March 2020, NHS England/Improvement (NHSE/I) issued a letter outlining the required interventions from the NHS in response to COVID-19; setting out specific actions for the NHS in order to redirect staff and resources as follows:

- Free up the maximum possible inpatient and critical care capacity
- Prepare for and respond to the anticipated large number of COVID-19 patients who would need respiratory support
- Support staff and maximise their availability
- Play our part in the wider population measures announced by government
- Stress test operational readiness

- Remove routine burdens to facilitate the above

3.53 In response, the following key actions were taken by LTHT:

- All elective activity was cancelled except urgent, cancer, life, limb or sight threatening surgery.
- All non-urgent outpatient activity was cancelled.
- To minimise risks to patients of COVID-19, wherever possible outpatient appointments have been converted to non-face to face through facilities such as video conferencing. Only essential face to face activity has been maintained.
- Due to the change in the way of working within primary care, routine referrals from GPs have not been received during the crisis. Urgent and cancer referrals continue to be referred and managed
- Significant expansion of capacity within Pathology for COVID-19 testing
- Expansion of Mortuary capacity
- All non-urgent routine and planned diagnostics were cancelled.
- Approximately 18,000 LTHT patients who are vulnerable were contacted by the Trust by letter. GPs were informed of which patients were contacted by LTHT
- LTHT has continued to receive 2-week wait referrals – however the referral rates have significantly declined during the COVID-19 crisis and are approximately one third of that expected at this time of year under normal circumstances.
- All cancer treatments are continuing wherever possible. All emergency and clinically urgent cases are continuing with their treatment plan where appropriate.
- In line with national/College guidance, apart from patients requiring very urgent intervention, some of the diagnostic testing has been suspended for example bronchoscopy, upper and lower endoscopy.

*COVID-19 patients*

3.54 During the pandemic crisis and at the time of writing this report, LTHT has had 887 cumulative inpatients who have tested COVID-19 positive. LTHT has also tested 1372 positive patients who have either not been admitted to hospital or have been admitted at other hospitals.

3.55 LTHT experienced a peak of patients between 9-17 April and have seen a gradual reduction since then; however the Trust still has a high number of COVID-19 positive patients (over 100) who are receiving care in the hospital. Sadly, as of 10 May 2020, the total number of reported deaths of people who tested positive with COVID-19 in Leeds hospitals is 277 (275 reported at LTHT; 2 reported at LYPFT).

*Nightingale Hospital*

3.56 The West Yorkshire Nightingale Hospital in Harrogate has been completed and opened on 23 April 2020. The hospital has passed approval testing and the site is being maintained. The hospital is ready to receive critical care patients and is available for use if needed as an overflow facility for critical care only. The management team for the hospital have returned to their respective host Trusts and staff who have been trained are back at their usual places of work; and will be mobilised if overall capacity requires the use of the facility.

*Recovery and service reset*

3.57 On 29 April 2020, NHS England issued a letter outlining Phase 2 of the COVID-19 response. In this, NHS England asked all local NHS systems and organisations to reinstate non-COVID-19 urgent services as soon as possible over the following six weeks. Amongst other actions being taken forward, Leeds Teaching Hospitals NHS Trust is implementing a phased response to reinstate non COVID-19 services. This will focus on:

- reviewing clinical priorities across all waiting lists
- repurposing areas from providing critical care to providing elective operations
- moving staff back from COVID care to their clinical specialty
- restarting elective activity
- increasing virtual patient appointments
- increasing testing of staff and patients
- increasing diagnostic activity
- increasing the use of the independent sector for surgery

3.58 NHS bodies expect an increase in A&E attendances and referrals from primary care compared to April.

Public Health

3.59 Public Health continue to work pro-actively on surveillance, prevention and control of COVID-19 in Leeds. The strong partnerships that exist between organisations in the city mean that we are in an excellent position to take co-ordinated action. In particular, work to develop local infection control plans, carried out by Public Health, Leeds Community Healthcare Infection Control team and Leeds Clinical Commissioning Group, is enabling the city to closely track outbreaks and provide effective support to care homes and community settings. This work is supporting the health and care system to safely manage COVID 19 outbreaks and to manage system flow. In addition, the wider Public Health directorate is developing work that will help the Leeds system to understand the unequal health impacts of the virus and how best to actively support the most vulnerable groups and communities.

3.60 Care homes remain a significant concern and the focus of ongoing actions, particularly in light of continuing challenges with securing Personal Protective Equipment supplies. There have been a number of care homes with confirmed outbreaks/cases of COVID-19. Health and Care partners have developed an action plan for care homes as we go into the next phase of response. This will ensure close support for partners working across the system.

3.61 LCC Public Health, working with Public Health England and Leeds Community Healthcare infection prevention service are providing a comprehensive response to support care homes. This focusses on: minimising infection and mortality levels, supporting the well-being of care home residents and staff, and safely managing access to care homes. The local system is providing simple, timely information and advice and, where care homes are experiencing difficulty, responding effectively and efficiently through daily contact with the home. In addition, weekly incident management meetings have now been established to coordinate efforts and target those homes experiencing high levels of infection and mortality.

3.62 Effective partnership working at a local level has helped to identify and develop local solutions to issues related to care homes. This includes: utilising local resources in order to improve the time taken for swabs to be delivered and received from care

homes during the initial outbreak testing phase; better communication of the results to primary care colleagues, and the implementation of testing for residents in community care beds.

3.63 The Public Health intelligence team are working with colleagues across the health and social care system to provide specialist support. This is enabling detailed understanding of the current and future impact of COVID 19 on the city, helping to track the position in Leeds and summarise global and regional trends to inform actions. There is a specific focus upon health inequalities. The intelligence team are reviewing information about deaths provided by both LTHT and local registrars, in order to understand how COVID 19 affects different population groups. The team are also actively pursuing information, held by Public Health England, about the location of cases and hotspots. This is important information to be able to access, in order to develop contact tracing, particularly in light of the potential easing of restrictions.

3.64 In line with the focus on Health Inequalities, Public Health have produced a COVID - 19 Health Inequalities report. It sets out the effects of COVID 19 on key population groups and on areas of deprivation. The report uses national intelligence about COVID 19 and combines this with what we know locally. This evidence based report is also being combined with the equality report compiled by the Communities directorate. Recommendations will be shared across LCC and with the Health and Social care system.

3.65 Public Health has also been working closely with CCG colleagues to identify and address the non-COVID health issues that have arisen over the last few months to ensure the impact on people and health inequalities is minimised.

3.66 Colleagues are involved in trying to influence the tracing and tracking programme that is being developed nationally, so that this works in a local context. This is a very live situation.

Mental Health

3.67 There is continued and growing recognition that people's mental health is likely to be negatively affected during this period. Public Health England have produced a suite of excellent resources which focus on protecting and promoting good mental health. They include advice for the general population (including children & young people, and pregnant women) along with targeted messages for vulnerable groups. The messages are being disseminated effectively through Mindwell and MindMate platforms (which have separate COVID-19 webpages) and the LCC funded Mindful Employer network.

3.68 Public Health and wider colleagues across LCC are also in the process of producing mental health guidelines for the wider workforce and volunteers. This is being developed in order to support staff/volunteers to feel confident when speaking to citizens who express emotional distress and/or suicidal thoughts

Dentistry

3.69 Nationally, routine dental appointments are not taking place and patients in need of urgent dental care should not visit (i.e. walk in to) their regular NHS dentist, nor should they visit A&E. However there has been growing concern regarding patients' ability to access to urgent dental care.

3.70 In early May 2020, NHS England issued a stakeholder briefing that set out that all NHS Dental practices remain open and accessible to patients; in order to provide urgent telephone advice and a triage service – referred to as a Triple A service (Advise, Analgesia, Antibiotics). The briefing also sets out that NHS 111 is also providing this service to patients as an alternative to NHS dental practices and Out of Hours.

3.71 In line with national guidance, dentists will clinically assess patients' needs over the phone. If a patient is assessed as needing a face-to-face appointment at a local centre, they will be advised on what to do by the dentist who will make the necessary arrangements.

3.72 It is also clear that the Triple A service should be provided to all patients, whether or not they have accessed a regular NHS dentist.

3.73 In Leeds, Urgent Dental Care is accessed via NHS 111. Treatment is provided 7-days per week, 8am – 8pm. Additional Urgent Dental Care capacity is being created across Leeds that will allow triaged patients to access urgent dental care as outlined above.

3.74 Subject to the availability of enhanced PPE, Urgent Dental Care Centres are being established in a minimum of 10 locations across Leeds.

Further health and care matters

3.75 Public Health continue to work with Healthwatch, Leeds Involving People and other Third Sector organisations to develop and disseminate a Community and Voluntary sector bulletin. This ensures consistent national public health messages are being used locally and can be tailored for vulnerable groups and populations.

3.76 Specific support for vulnerable groups includes work that Public Health teams are undertaking to ensure that rough sleepers, when placed into emergency accommodation, receive support and treatment for drug and alcohol issues. Notably, Forward Leeds report that this arrangement means staff have been able to contact service users more easily, and service users have commented that assessments are of a higher quality.

3.77 Public Health teams have also been working with the Leeds Housing Options team and a number of other partners to mobilise, organise and deliver food supplies to vulnerable people in Leeds, living in temporary accommodation due to COVID-19. These deliveries have been made to over 200 people who have been placed in temporary accommodation in hotels and other properties in locations across Leeds.

3.78 The integrated sexual health service continues to offer essential clinics. All patients are triaged by phone and contacted by a clinician. Patients who meet the urgent criteria are seen face to face. Remote online testing continues with the offer to receive treatment by post. Prevention services have adapted their offer and are supporting those most at risk via telephone and zoom calls, postal condoms are also available.

3.79 Leeds 0-19 Public Health Integrated Nursing Service (health visiting and school nursing) continues to provide antenatal and birth visits to all families. The first line of contact with families is currently via telephone or video-call; however home visits (with

appropriate use of Personal Protective Equipment) continue where there are concerns. Working closely with children's centres and children's social care the service continues to offer additional 'universal plus' contacts (extra support) and contacts with vulnerable families ,where required.. The service is currently re-setting its offer following new guidance regarding the second phase of the NHS response to COVID-19. This includes preparing for the re-introduction of the 6-8 week infant check and more resources to be dedicated to perinatal education.

3.80 **Infrastructure and supplies:**

3.81 The supply of PPE remains a key focus as both local and national management efforts are being made in response to the challenges of supply across the health and social care system and wider sectors across the city. The PPE task group led by the Director of Adults and Health continues to support the effort to address the shortages in areas of the system considering stock control, understanding and compliance with the guidance, mutual aid, and sourcing additional stocks for the short and longer term. The management of PPE and volume of supplies to care homes is a particular concern and the councils has moved to further support this effort by creating a system wide group of meeting regularly to respond to and complement any national developments.

3.82 Management of PPE stocks has also been extensively supported through collaboration with the WYLRF, as the government continues to use this route for emergency drops of stocks. With arrangements of distribution to the five WY councils, via the drop hub location in Kirklees, recent activity has seen a strengthening of the established communication channels and implementation of robust systems for improved visibility of stock at each of the hubs. Due to the concerns over PPE shortages in NHS hospitals, social care and emergency services the Leeds City Region Enterprise Partnership (LEP) and West Yorkshire Combined Authority (WYCA) are working with partners including the council and LRF to support businesses get the crucial supplies to health and social care workers. The LEP is supporting existing activity, principally in the identification of potential suppliers and the verification of capability, connecting PPE providers to the existing supply chain. Moreover, it has also established a support package for businesses who wish to adapt to manufacturing PPE, whilst also mobilising business networks to identify firms to assist in the scale up of re-useable supplies where required.

3.83 The council also continue to monitor the disruption to their supply chains in other key service areas such as catering services (e.g. school meals) and cleaning services. Actions are in place to respond to these issues with extensive liaison with suppliers about stocks and payments.

3.84 The Silver multi-agency group leading on the infrastructure and supplies strand of work continues to engage with relevant partners feeding concerns raised as well as progressing responses to address further issues identified.

3.85 In terms of infrastructure and more specifically transport, 24 hour weekday traffic levels in the last week were the highest since mid-March, continuing the trend of increasing traffic in recent weeks. They were down 53% compared to the beginning of March and 49% on the same week in 2019. On average, flows were up 3% on the previous week. Morning peak flows were down 66% compared to the beginning of March and 60% on 2019 (this includes the effect of the VE Day Bank Holiday), pm peak 52% and 48%. Compared with the previous week, and excluding the Bank

Holiday, am and pm peak flows were up 5% and 8% respectively. On the weekend of 9/10 May traffic was down an average of 61% compared to the beginning of March and 58% on the same week in 2019. These represent the highest levels of weekend traffic since mid-March with flows up 2% on last weekend. Analysis of other automatic traffic count sites located away from Leeds city centre shows similar levels of change.

3.86 Road traffic casualties recorded in the first 18 weeks of 2020 have been analysed and compared with last year, for all casualties, car occupants, pedestrians and children. The overall reduction in the number of all casualties and those KSI during the first 18 weeks of 2020 is reflected across all the road user groups. All casualties fell by 40% from 643 in 2019 to 383 in 2020, while those KSI have reduced by 38% from 117 in 2019 to 73 in 2020. From week 12, despite some random fluctuations, the number of casualties has substantially reduced regardless of the mode of transport. The total number of all casualties fell by 64% from 236 in 2019 to 86 in 2020, while those KSI went down by 54% from 43 in 2019 to 20 in 2020.

3.87 Prior to but also in line with recent announcements, the council as a highway authority is pushing forward with plans to promote active travel across the city. This very much reflects the significant social distancing challenges the city is faced with in the short, medium and possibly longer term, primarily as a result of public transport capacity being significantly constrained. An initial major piece of work to review the city centre and local centres for social distancing “hotspots” has already been completed and there will be engagement with local ward members on proposals for areas which they represent. A Commonplace public consultation exercise is also set to be launched to gain feedback from the general public about locations of concern and to aid the prioritisation of the introduction of remedial measures. Such an approach was used with positive effect during the development of the Leeds Public Transport Investment Programme and it is hoped a similar positive public engagement can be achieved.

3.88 The pace of implementation of measures is key here as lockdown starts to be eased and social distancing issues become apparent. An “orca and wand” scheme to improve cycling facilities along the A65 has recently been quickly consulted upon with local ward members with a view to work starting in the near future. Measures have also been introduced prior to the bank holiday weekend at a number of sites in the city centre to widen footways and address potential social distancing “hotspots”. Subject to procuring significant quantities of relevant equipment, funding being made available and feedback from local ward members, the intention is to roll out similar measures across the city as soon as possible. The intention will be to implement and adapt measures as lessons are learned and feedback is received. Relevant bronze and silver meetings have been established across Directorates to coordinate and develop this work stream.

3.89 The opportunity is also being taken to fast track where possible schemes under development. These have included the city centre 20mph scheme and City Connect 3 project.

3.90 Following the recent announcements of £250m being made available for COVID19 related measures, there will be a need for a strong communications plan sitting alongside this work. A plan is currently in development to reinforce the current message of encouraging people to work from home and to cycle and walk wherever possible if there is a need to travel. The details of how to access the funding is expected in the near future.

3.91 Work continues on the Highway Authorities'' major schemes and infrastructure programmes of work. Positive feedback was received from most of the utility companies at a recent meeting around service diversions linked to the council's major schemes and a willingness and resources to undertake such work.

3.92 WYCA, as transport authority continue to coordinate bus operational matters via WY Bus Alliance. The Key Worker Network has been in operation since 30 March and jointly agreed with operators. The Park & Ride services in Leeds ceased operation on 30 March and the Temple Green site is now an NHS drive through testing site. Operators in the last week have reported a slight increase in patronage from circa 13% to 17% of standard weekday but free bus pass use is around 10% of a standard weekday. The bus stations remain open with social distancing for staff and customers although the Travel Centres in bus stations have been closed since 24 March. Driver safety is a major concern and whilst operators are taking precautions, there will inevitably be major pressure for worker PPE. Clarity for passengers around the wearing of and the supply of PPE will be a key issue going forward. Moreover, AccessBus services ceased operations on 10 April but the vehicles are being used to support community initiatives in Leeds and serving anti-coagulant clinics in Leeds.

3.93 In relation to rail services, DfT have suspended franchise contracts and operators are working to a service contract. Similar to bus operations, very low patronage levels are being reported with Northern reporting 8% of normal weekday patronage depending on the route selected and Open Access Operators - Grand Central, Hull Trains suspending services until June; again, similar to bus operations a key worker network service has been established with the Leeds – Harrogate service moving to half hourly operation since 12 April to support the Nightingale Hospital being a good example. More recently, it was noted National Rail will be moving to a "key worker plus" timetable on 18 May and no significant driver/ train crew availability issues are reported.

3.94 All transport companies are preparing recovery plans in anticipation of passenger increases and are working through a number of scenarios as to how to operate with assumed social distancing rules and requirements for PPE. Service frequencies are set to increase on rail and bus to circa 70% of normal timetable in the coming weeks but social distancing will adversely limit capacity to circa 15%. This will have a dramatic impact on capacity which will mean for example, approx. only 15 passengers on a double decker bus. The government's message in relation discouraging use of public transport will also require ongoing clarification and discussion given the reliance on such services by many key workers.

3.95 Leeds Bradford Airport are also in the process of developing a set of air travel standards required for international travel, outbound flights will be dependent on meeting these standards. PPE and social distancing rules remain a concern to the operations of the airport.

3.96 **For the council estate:**

3.97 Linked to the organisational section below, for council colleagues, Asset Management and Regeneration and colleagues across Facilities Management and Human Resources worked rapidly to close down the physical estate in response to the lockdown provisions. Whilst this was a multifaceted process it is widely accepted that the reopening will be more complex as it responds to new social distancing

measures, continued need for enhanced home working and a significantly reduced transport capacity.

3.98 These teams are further working on a “Mobilise and Energise Programme” for the council. The programme of works is focused on two key areas of; continued home working through the theme ‘Working from Home First but Better’ and ‘In Place’ which is adapting and accelerating the use of our buildings to enhance wellbeing and productivity for our colleagues, customers and partners.

3.99 The occupation of our physical estate will respond to government COVID-19 Alert levels and allow Leeds City Council an agreed protocols and principles to be responsive as the Alert level fluctuates over time.

3.100 Our Office based staff will continue to, in the first instance ‘Work from Home But Better’ and we are accelerating plans to improve productivity of those doing so through three key areas of equipment, training and service transformation through digitisation. This supports how we plan to minimise the impact on the transport infrastructure and capacity in our physical estate as well has supporting wellbeing.

3.101 The ‘In Place’ workstream is adapting the physical estate to pivot the provision of physical space under the themes of Comfort, Contact and Collaboration. Comfort provides for a safe working environment for those who do not have this in the domestic setting for whatever reason; Contact will provide space for where face to face provision can greatly enhance service such as for Registrars and Collaboration as Alert levels reduce and greater physical collaboration will enhance wellbeing and productivity. To achieve this we are working across the Council and with our advisors and suppliers to transform work flows and physical layouts.

3.102 For illustration Alert level 4 capacity of the estate has been calculated to meet the Social Distancing guidelines which on current assessments is providing a site utilisation in the range of 20 to 30% depending on building configuration including communal and circulation areas and use. In addition refreshed user principles are being drafted to provide for a safe working environment including appropriate cleaning regimes and extension of building opening hours to stagger occupation. Building liaison managers will also be provided to assist colleagues with onsite needs and practices. We plan to extend meeting room booking facilities to include desk booking to ensure Social Distancing and capacities in buildings are maintained and where possible use electronic access control restrictions to align such. We are providing a mock office for testing and training purpose and will continue to work through the various buildings in the estate to review and adapt accordingly.

3.103 This work stream is being coordinated under the bronze structure of Mobilise and Energise.

3.104 **For the city more broadly:**

3.105 The council is also working with other public sector anchors including University of Leeds, Leeds Beckett University and Leeds Teaching Hospital Trust to share best practices, insight and coordinate activities across our respective estates. In addition a private sector landlords group is now meeting to look at their refreshed and adapted

best practise to influence their estate's requirements and the two will come together regular to collaborate.

3.106 These accelerated changes in estate practises will also influence footfall and traffic flow into the city and a willingness to share ideas and approaches on property capacity and management issues across the public and private sector is welcomed by all.

3.107 Huge challenges are also faced by our education providers such as universities. Students and staff continue to work and study from home and it is unlikely that staff will return in to workplaces soon as they will be part of the city office based staff phased in at a later date. The Returning Steering Group are making plans to allow some face to face contact to return mainly in the laboratory and workshop settings. Both universities have seen an increase in applications although residency applications are down. The challenges faced by the universities is not just operational but also has a cultural impact too. The operations in relation to the studying environment such as in libraries and the lecture theatres are to be worked through as well as side by side seating in classrooms. Equally challenging will be the shared recreational space for a culture that thrives from interactivity such as shared lobbies, recreational space, raising challenges to universities. In response to this, and working with the social distancing advice the council and universities are working together to consider practical guidelines and to test a number of pilots around shared space setting, access and egress, access routes through the building so that the learning needs can continue and as well as supporting the cultural experience of the university environment.

3.108 The partner organisations as well as internal services such as CCM (City Centre Management), Economic Development and Asset Management continue to work together on the guidelines as well as assess data, footfall and intelligence on the phasing of the different work groups. They will continue to monitor how these groups scale up in numbers in order to be proactive as well as reactive to the shifts in commuter, consumer, visitor and employee behaviour and confidence. A strong link with communications team will be essential along with briefings of travel and access into the city aligned with government announcements.

3.109 **Business and economic impact:**

3.110 Leeds continues to progress its response within the context of the Inclusive Growth Strategy and working with businesses, stakeholders, community groups, and through representative bodies to monitor and understand the impact on our economy and provide support where possible. Information is collated regularly relating to specific areas of business and the economy to support with monitoring impact measurement. Weekly meetings with business representatives and independent businesses continue to take place, alongside existing business support arrangements to share information and details on our collective response (working closely with WYCA/LEP). The council is also engaging further with the LEP as the focus also turns to economic recovery, understanding the challenges and opportunities facing local economies during this next phase.

3.111 The PPE Coordination Team are continuing to support with emergency PPE needs, working with partners at an international, national and city level to address the PPE challenges and procure and source supplies.

3.112 In terms of communications, the coronavirus - help for business webpage on the council website is being updated continually with information and guidance on support available from both local and national government.

3.113 The council continues to make good progress in processing grant payments for the Small Business Grant Fund and the Retail, Hospitality and Leisure Grant Fund. As at 15 May, 10,598 grants have been paid totalling £130,805,000, with over 75% of the initial allocation to Leeds paid to support businesses. This also makes Leeds consistently one of highest performing local authority by amount paid (according to BEIS figures updated at 11 May). We estimate these grants will help a total of just over 12,500 businesses in Leeds, and whilst this funding and further announcements of support for businesses are welcome, continued challenges remain.

3.114 Using the business rates system, selected for its speed of delivery to administer business grants, has led to some anomalies resulting in some businesses being excluded from support as only eligible rate payers qualify under the current criteria. The council and its partners have continued to press government for assistance for these businesses through various channels. The government has responded to this call for funding, with the announcement of the new Local Authority Discretionary Grant Fund detailed in the background of this report.

3.115 The council is also further supporting to drive the effort to enable the city to prepare for the future during the coronavirus pandemic as it increases conversations with partners around how to create safe work and education places, public spaces and public transport as restrictions begin to be eased. The Leader of the Council and chief executive recently joined leaders from organisations across West Yorkshire at the first Economic Recovery Board, to get to work on supporting people and businesses to recover from COVID-19. The Economic Recovery Board is chaired the Leader of Bradford Council. There has also been an officer group established to support the work of the Board.

3.116 Businesses particularly affected include suppliers to retail/hospitality and leisure industries; businesses who's rate liability sits with a third party – in most cases their landlord; the self-employed who work from home/don't have premises; and those in shared workspaces that for business rates purposes are classed as one property. The council is continuing to deal with more complex cases and to work closely with landlords to get grants to tenants where possible.

3.117 As mentioned the three key strategies underpinning the work of the council remain incredibly important including the Inclusive Growth Strategy and these will need to be renewed, refreshed and aligned to take account of the current crisis. In this context, work has commenced to review and refresh the Inclusive Growth Strategy. We will use the Inclusive Growth Delivery Partnership to help shape recovery and move forwards. We are also assessing how we can consult and hold a conversation with partners and citizens. An initial review of the overall Strategy will identify potential areas that will need attention, followed by a rapid review of the 'Big Ideas' with the aim to identify areas where we need to Start/Stop/Accelerate work. Senior Officers will be engaged on reviewing the Big Ideas, through the Inclusive Delivery Group including with elected members. As part of this review we will also bring forward our work on the Social Progress Index, which we are proposing to use to measure inclusive growth

3.118 In order to support SMEs during this period of uncertainty, the council has also recently launched the Leeds MicroBusiness Support Service which provides support to businesses across the city, particularly to independents and those in the retail sector, through the provision of online resources and information, and a dedicated one to one telephone support sessions with local businesses. To the 4th May, there were over 2,900 page views of the site and a series of webinars have been completed on topics including helping businesses plan for the future, how to grow an online business and manage finances. One to one support has been provided to various types of businesses including professional services, restaurants, arts venue & bar, dogwalker, print and media and a bridal shop. Typical enquiries have included financial support; uncertainty about the future; and online marketing.

3.119 The council will also continue to support our commercial tenants who continue to be invoiced during this period. We are offering support to businesses that have been impacted on a one-to-one basis. We will also pause any recovery action on commercial rent collections for the next three months, after which time this will be reviewed.

3.120 While face to face services are no longer delivered and the Council's Jobshops are currently closed, the Employment and Skills Service has continued the delivery of existing employment support programmes to over 1,000 residents with check-ins and online learning, job searches, CVs and matching to vacancies by qualified Employment Advisors. We continue to promote current vacancies including roles in food retail, logistics and distribution, construction, health and care through the Council's webpages and social media and recorded 78 job outcomes for local residents during April. New customers, and those now being referred for support by DWP, are able to visit Leeds Employment Hub website if they require support to re-enter the labour market and for advice about which businesses are currently recruiting.

3.121 The service continues to use on-line classrooms and learning platforms to deliver the Council's Apprenticeship Programme and is implementing a programme to enhance the capacity of our Adult Learning providers to deliver on-line courses during the current term to offer new or blended provision from September 2020. New activities have been posted to StartinLeeds, the careers education platform to continue to support young people considering their next steps in education and employment and the Career leads in schools are being updated on the current apprenticeship vacancies with local employers by our network of apprenticeship training providers.

3.122 We have also developed guidance for commissioning managers within the council to ensure they can support suppliers as and when they contact the council for support as a result of being adversely affected by the coronavirus outbreak. The guidance takes a sympathetic but proportionate approach and seeks to triage suppliers that most need financial support to the relevant approach, whether that be existing support measures, alternative or reduced services, additional council support measures for "at risk" suppliers, or a combination of these.

3.123 The council is further continuing to work with various sectors to offer advice and support, such as the Creative and Arts sector and is able to link organisations with local and national funding and support opportunities, available on the website. We are also involved in work which brings together West Yorkshire authorities to understand the impact the crisis is having on the creative sector, with the aim of

presenting a business case for support as we move from the current phase of response toward stabilisation and then recovery.

3.124 The council and West Yorkshire authorities have launched an online regional survey of the creative sector on the impact of COVID-19. The results will help inform the priorities for any further support for the sector going forwards. The Leader of the Council and officers have met with the Arts Council England to further discuss the needs of the sector.

3.125 On tourism, Visit Leeds has developed an initial recovery plan which will be refined as more detail emerges on the lifting of restrictions. Welcome to Yorkshire is also leading a series of tourism sector recovery meetings bringing together partners across the region with Visit Leeds also involved.

3.126 Moreover, in terms of providing support to investors and the community, the Planning and Building Control Service has contacted customers, setting out the level of service currently being provided. Officers are also in contact with the West Yorkshire Authorities and Core Cities to share current emerging best practice. The Planning Service are currently in the process of developing provision of remote meetings for example, Plans Panels, with the development of a Remote Plans Panel Protocol which has been circulated and communication with developers. Both the Planning page and the coronavirus business pages are regularly being updated on leeds.gov.uk.

3.127 Whilst major events in the city have been cancelled or postponed the council continues to work with partners to maintain engagement virtually including via major events such as the largest tech event in the UK in the Leeds Digital Festival earlier in May. Turning virtual for two weeks, 130 online events were held. The response to the change in format of the Festival has been overwhelming and has shown an exceptionally positive response to a very difficult situation, enabling a reach beyond the Leeds City Region, with some events attracting attendees from five different continents.

3.128 **Citizens and communities:**

3.129 Leeds strength is in its rich diversity which benefits from people from different ages, backgrounds, cultures and beliefs living and working alongside each other harmoniously. This diversity is supported by our compassionate city ambition which influences the way we work and the strong focus that is placed on protecting and supporting the most vulnerable in our society.

3.130 The role of elected members remains crucial in this context supporting the overall approach of the council. Councillors have been active in their wards, providing democratic leadership and working with local people and local organisations including via the volunteering hubs to support the most vulnerable in local communities. Elected members have also had access to utilising local resources, including the £10k ring fenced funding from the 2020/21 allocation of wellbeing fund to support local activity. The Community Committee Chairs forum has been re-convened by the Executive Member for Communities to ensure appropriate oversight of community related activities by the Chairs and to review the Wellbeing and Youth Activity budget. A number of community committees have also been convened by their Chairs and these have met on a consultative basis in April to ensure that activities across wards

is joined up and challenges fed through to the appropriate services. The Communities Team is also progressing work to provide a baseline budget position so that committees can consider the decisions that have been made in the March round of community committee meetings and progress them through the delegated decision making process.

3.131 The council working in collaboration with Voluntary Action Leeds (VAL) and local third sector organisations continues to provide the necessary additional support, particularly to the most vulnerable people in the city. A coordinated approach to volunteering has been rapidly introduced from a standing start to deliver care to anyone in need across the city. 330,000 leaflets have been post-delivered to households promoting the local offer of support and the council's coronavirus helpline which have also been translated into 12 community languages. 33 ward level Facebook pages have also been created and are being actively used to post updates and information.

3.132 The 33 Volunteer Coordinator Hubs across each ward in the city are now supported by 5,200 volunteers, with VAL providing ongoing support and guidance to the volunteers and the third sector organisations involved. These hubs are managed by third sector organisations, who continue to coordinate referrals for support, match volunteers and source the much needed food and prescriptions required by those who are self-isolating, the shielding cohort, and those who are facing difficulty and have no other means of accessing these vital resources. During the period 24th March – 28th April, 5629 referrals have been made to the hubs, with a significant increase in calls to the helpline since the leaflet drop took place.

3.133 The Council adapted its Local Welfare Support Scheme (LWSS) and its frontline customer service workforce in the current context to provide a COVID-19 helpline. This provided two telephone helplines to arrange emergency food provision and non-food support. A new warehouse facility was also launched, designed to provide a central location in Leeds for food storage and distribution, linking fleet vehicles and drivers for food deliveries and collections. As of the 12 May, 11,000 calls for support have been answered from both helplines and over 10,000 food parcels have been packed and distributed since the service began.

3.134 Alongside the food provision supported by the council, charities such as FareShare, local businesses and the third sector, two supermarket voucher schemes are also in operation to allow volunteers to carry out shopping for residents that are unable to shop for themselves. The voucher scheme works in two ways:

- Free Vouchers allow volunteers to carry out shopping on behalf of the customer, and are available to customers in financial hardship.
- Paid Vouchers allow volunteers to carry out shopping on behalf of the customer and the customer will then be invoiced by the council. This service is available to customers who can afford to pay, but are unable to leave their homes due to social distancing.

3.135 A process for voluntary organisations is being developed to monitor how vouchers are being spent and an eligibility process which will be introduced to tackle potential abuse of the system and to ensure the service is supporting to those most in need.

3.136 In late March, the NHS identified a number of medical conditions where there was a significant risk of complications if the person contracts COVID-19. People with these

conditions were advised to shield for 12 weeks. Specifically, this means people were advised to:

- not leave their home
- not go out for shopping or exercise
- strictly limit all contact with people from outside their household
- minimise contact with people even within their household, observing social distancing at home wherever possible
- ensure any deliveries are left at the door
- strictly avoid any contact with someone who is displaying any symptoms of coronavirus

3.137 Based on original estimates of numbers, Leeds was estimated to have had a shielding cohort of 22,532 people. However, this was based on people with the specific conditions identified by medical experts that would make them extremely medically vulnerable. In subsequent weeks, secondary care and primary care have done an extensive search of patient records, to identify patients whose combination of conditions would also raise their risk from "moderately vulnerable" to "extremely vulnerable". The new estimated figure as of 11th May for people in Leeds advised to shield, is now 45,713, over twice the original estimate. Other areas of the country have also seen significant increases in numbers advised to shield. Work is underway currently to better understand the scale of the increase.

3.138 To date 16,099 people (67% of the original cohort, or 35% or the new expanded cohort) have confirmed they have received the letter to shield by registering with the national shielding service. This marks a significant increase in the numbers of people who have registered in the last three weeks, and may reflect significant efforts from local partners to increase registrations, including raising awareness and providing practical assistance to do so using existing contact with services: specifically housing, social care and primary care. As well as asking all organisations in the city who work with people to raise awareness of the advice and process around shielding. Given the substantial increase in total numbers for the city in the last week, this will remain a high priority.

3.139 Using the Leeds Care Record for the original cohort of 22,532, we were able to break the data down by ethnicity – and this shows some particular concerns that people from minority ethnic groups may not be receiving or understanding the advice to shield. People of Pakistani or British Pakistani origin have the lowest confirmed registered rate of all single ethnic groups in Leeds, with only 119 individuals out of the 353 sent letters (33.7%) registering through the national programme. Followed by Black African identities at 34.2% and Black Caribbean origins at 38.4% registration rate. Given this clear evidence, and the national trend that people from BAME backgrounds account for a disproportionate amount of COVID-19 related deaths in the UK, we will be targeting efforts to ensure that information about shielding is shared in minority ethnic communities across the city, working with third sector organisations, faith communities and sharing this data with primary care, particularly in areas that have higher numbers of BAME residents.

3.140 Additionally, we have been able to map where people advised to shield are living in the city. A significant proportion of people advised to shield 12,047 (26%) are living in areas ranked in the 10% "most deprived" nationally. Whilst the conditions that provoke the shielding advice affect people across all socio-economic brackets – it is

clear that the impact of shielding will be more keenly felt in households with lower incomes, including a higher proportion of people on low wages who are unable to work from home, increases in household expenditure and the difficulty of shielding in homes where physical distancing from other members of the household is more challenging. Shielding has only intensified the impact of existing inequalities – where health status, identity, spending power and social literacy all interplay.

3.141 Of the 16,099 confirmed registered in Leeds, 4,628 people have said that they would need help with accessing food and basic supplies. 1,221 of these (26%) regularly receive a Basics Box delivered by national government, a further 486 have received one Basics Box delivery and 491 have asked to be removed from these deliveries permanently. The rest are offered support by our local volunteer support, food banks or informally through neighbours. Since the week commencing 27 April, the council has also been sent details of 1,203 people who say they may need some assistance in meeting their "basic care needs". As there is no further information provided, a significant piece of work is now underway to cross reference this with local requests for assistance that are already being processed, before making contact. In addition, we estimate that the significant increase in overall cohort size, will possibly double this demand, and may have significant resource implications. It is also likely that there is a higher proportion of people with unmet needs in the people who have not yet registered.

3.142 When people register each day through the national programme and indicate they may need some assistance, the local shielding team in Leeds send a text communication to people with mobiles, make a call to people with landlines, emails people with no phone number or sends a letter to individuals where no other contact details are available. This is to inform individuals of the local support available through the Helpline and local volunteers and advises them that they can ask for help at a later date, even if they do not need it now.

3.143 Periodically, the local shielding team also provides updates to all people who have confirmed they are shielding, with largely practical information about where to get help with accessing food, welfare support or social support. Tracking on the information sent through email (to 8,544 shielding recipients) show that engagement is high – with a minimum 72% "open rate" and only 1 unsubscribe from the mailing list, indicating that residents find these local updates useful. The multi-agency bronze group is also considering using these communication channels to send health and wellbeing information on staying well during the period of shielding. We anticipate that this will be particularly important for the coming period when messages about national lock down are changing, but the advice to shield remains.

3.144 Much of the national shielding programme is predicated on sending clear instructions to people on avoiding contracting COVID-19 in order to make them aware they are at higher risk for complications or even death, this however does not allow much opportunity for people who have been advised to shield to provide feedback on the things that would enable them to shield most effectively as individuals. This is possibly illustrated in the low take up of people accepting the basics food boxes, despite the national offer that it is free and delivered to the door. The vast majority of people who are shielding would prefer to pay for and choose their own shopping, but the distribution of priority delivery slots from supermarkets remains unclear and hard to

obtain. Therefore, it is imperative that we open up communication channels with people who are shielding to express their views, ideas or on what we can do to help them stay happy, healthy and at home. We consider it essential to their mental and physical wellbeing to be active participants in taking informed decisions on their own health, supported and backed by a logical set of arrangements that keep them safe and reduces risk, costs and unnecessary stigmatisation.

3.145 Indications from Government are that a period of advised shielding is to be extended for some time yet. This will mean a significant undertaking for people who are shielding, but also a shift in how we ensure planning and the necessary resources to support people beyond this initial emergency phase.

3.146 The approach in Leeds to date has been to use our existing strengths – working as one joined up health and care system, working with local partners to maintain trusted sources of support and to approach the support we can provide locally through a model that puts people at the centre of their own lives, and we as active partners in their welfare. If the advice to shield from national government does remain in place over a longer period, it is essential that as much as possible, we can maintain this balanced relationship.

3.147 Working across West Yorkshire we have established a strong route for communication with central government, and the Multi Agency Bronze on Shielding has begun compiling a report on considerations for shielding post lockdown. This will include a range of issues including the reopening of schools, continued food supplies, health and wellbeing and work and employment. There is a significant role for local authorities to support the ongoing welfare of people who are shielding and there are considerations for how this is resourced for an increased number of people and for an extended period.

3.148 Moreover, in order further strengthen the understanding of national shielding policy implementation at local level the government has established a Stakeholder Engagement Forum (SEF), bringing together the regional lead Chief Executives and representatives from LRFs. The Yorkshire and Humber Chief Executive's representative on the SEF is the Chief Executive of Bradford Council. The national shielding team has also recently established a local structure and regional teams with named civil servant contacts for each local authority enabling a further route to identify and raise issues related to the programme for a response.

3.149 The council is also expanding its local offer working partnership with Leeds Older People's Forum and Voluntary Action Leeds by introducing the 'Are U OK? Service' to complement the volunteering effort and provide support for people who have indicated they would welcome a welfare check call. Information on this service will also be been sent directly to people who are shielding.

3.150 Additionally, all families with children who are advised to shield are being sent a letter containing relevant information and signposting to local support specifically for children and families.

3.151 More broadly, the council will continue to monitor the demand of the local support offer to ensure its sustainability if required and to inform the scoping of the next phase of development of the volunteering approach in this city. It is anticipated that the number of calls for support will reduce as the local connections between the

hubs/other local third sector organisations and individuals are increasingly established directly.

3.152 In schools, Civic Enterprise Leeds (CEL) continue to provide catering support to those pupils who are eligible for Free School Meals. The current weekly figures are approximately around 7,090 Grab Bags, 2,700 Hampers, (which is the equivalent of 13,500 meals), plus a further 1,000 hot meals, this amounts to 21,590 meals to Free School Meal children per week. Hot meal provision within Specialist Inclusive Learning Centres (SILC's) , adult social care residential homes and recovery hubs has been consistent since the beginning of close down as well as early years catering provision in the Early Years Centres which remain open for children or new children of key workers.

3.153 The Meals at Home function has maintained its 7 days a week service and has seen a 25% growth of daily meal numbers to 800 a day during this period. The same service has been supporting the community with providing food for individuals who are homeless and currently in temporary accommodation. We have also been working closely with our suppliers and partners to support a number of community initiatives. Over this period this has included support for a soup kitchen with a range of donated fruit and vegetables, the distribution of surplus sandwiches as well as donating food products to various community groups.

3.154 The latest figures for Leeds indicate a significant increase in Universal Credit claimants since the coronavirus pandemic took effect in the UK. Access to free, independent, impartial and confidential advice is vital to contributing to the council's ambition of a strong economy and compassionate city. Effective and good quality advice supports people to lead sustainable lives through maximising incomes, dealing with debt, resolving housing issues and gaining training and employment opportunities. Recent engagement with advice service partners has revealed calls regarding welfare benefits and UC queries are the top issue since the start of the lockdown period. The relaxation of benefit rules and offers of payment holidays amongst mortgage and energy providers has eased the pressure in terms of demand for debt advice. However, the advice services are anticipating a surge in demand for debt advice once repayments become due, forbearance measures come to an end and the true economic impact of the pandemic takes hold.

3.155 To support residents affected by the pandemic with Council Tax payments, the council has introduced an option for residents to defer payment by up to 3 months and reschedule payments over the remaining 9 months. The Council is working with residents to ensure customers understand that they should only seek deferment if they cannot afford repayments, and is encouraging customers who can afford to pay to continue as normal. Latest data has shown that 3,500 Leeds residents have applied for the 3 month deferment to repay later in the year. Leeds also provides the Council Tax Support Scheme to eligible residents on a low income. There have been 1,700 new claims for Council Tax Support since the outbreak. The Council's Housing service is further working to support tenants facing financial difficulty by suspending normal recovery action for 3 months, providing advice in relation to support of benefits to assist tenants with rent payments. Again, the true impact on Council Tax and Housing rents may not be known until lockdown is eased and forbearance measures come to an end.

3.156 In terms of the response to support those who are homeless and rough sleeping the council has been working to ensure all those who require urgent accommodation are assisted with a number of options introducing hotel rooms at a number of locations were sourced and with a focus on a triage approach around 'Protect', 'Care' and general population needs. Specific hotels were also introduced to support women and those fleeing domestic violence. 215 individuals have temporarily been rehoused and we are now working on assisting individuals in hotels moving to more settled accommodation and will continue to do so over the coming months. The Housing service continues to consider planning arrangements following an easing of lockdown which will be overseen by the Street Support Improvement Board, developing a partnership co-produced recovery framework.

3.157 Contact to national domestic violence helplines have significantly increased and evidence suggests that incidents are becoming more complex and serious. It is within this context that Leeds has worked quickly within existing resources to respond to the immediate challenge of lockdown. Domestic violence and abuse incidents in Leeds are very high and have remained at this level consistently throughout the lockdown period.

3.158 At the start of lockdown the council moved swiftly to launch a DVA social media campaign to promote the support available for people experiencing domestic violence and abuse and linked to the "You Are Not Alone" national campaign. The Leeds Domestic Violence Service moved quickly to mobilise a business continuity plan that ensured services could be delivered with social distancing measures in place. The commissioned refuge service is open and is currently full and LDVS is working closely with Housing Leeds through the Emergency Lettings Panel to re-house families and release the refuge units when occupants are able to move on. Other temporary accommodation is available through the hotel infrastructure commissioned during this time and a decision was taken to re-house any individual presenting as a victim of domestic violence regardless of their immigration status at this point time.

3.159 Safer Leeds moved the daily Domestic Violence and Abuse MARAC to a virtual meeting as part of their early COVID-19 business continuity planning arrangements The MARAC has continued to run daily and ensures there are safety plans in place for people who are assessed as high risk. There is an average of 14/15 case a day. Children and Families services are a key partner in this front door activity and are continuing to support a range of children and their families who are experiencing domestic abuse and violence through the Early Help Hubs and more direct contact with social care services.

3.160 The local authority has recognised that we now need to be pro-active in organising our collective response to potential surge activity as we move out of lockdown. A new COVID-19 DVA Tactical Response Group has been created which meets virtually on a weekly basis to ensure there is a good understanding of visible DVA presenting need and that there is a shared tactical plan for priority themes. It is likely that this programme of work will mirror the recent focus of national discussions on the Domestic Abuse Bill covering; access to information and support, response to support services for BAME communities and specialist services, housing support and refuge accommodation and a strong criminal justice response. Initially this will be explored

within existing resources but the council will work to support third sector partners as they bid for the grant resources announced by government.

3.161 As highlighted in this report the coronavirus pandemic has placed unprecedented demands on the need for and supplies of PPE. The Citizens and Communities directorate has also played a key role in the response to this demand supporting three strands of focus: safety of LCC staff; safety of volunteers; and supporting the wider work of the Local Resilience Forum (LRF). There have also been many examples of mutual aid between organisations. This has involved joint procurement exercises, exchange and donating supplies as well as sharing best practice. There has also been a community effort involving local suppliers, people/schools/companies making PPE; and elected member donations from their contacts at home and abroad. To date, an adequate supplies of PPE to comply with national guidance, has been maintained throughout.

3.162 In terms of temporary mortuary provision, the development at Waterside in Stourton is now complete and available for use by Leeds and Wakefield. Mortuary capacity within the hospital trusts and through funeral directors has thus far been sufficient to cope with the number of excess deaths in recent weeks, therefore, Waterside whilst available has not yet been placed into operation. The capacity at Waterside will remain in place to support any potential future waves of COVID-19 deaths and will be kept under regular review.

3.163 A series of new measures were established to help keep families and loved ones safe during services at the council's cemeteries and crematoria. This included putting limits on the numbers of people who could attend a burial or a cremation and closing our crematoria buildings for public access including cremation services. We have continued to work closely with funeral directors to ensure that bereaved families are able to find the most appropriate way of paying their respects for their loved ones at this challenging time. This includes making alternative arrangements for services either through chapels managed by funeral directors or through a local church; by delaying a chapel service until restrictions have been lifted; or by attending the crematorium grounds and viewing the coffin being moved from the hearse into the chapel with the potential, should families wish, for their officiant to do a short blessing outside of the crematoria chapel in view of the bereaved family. In accordance with national guidelines, all cemeteries and crematoria grounds have remained open to the general public subject to social distancing guidelines being adhered to.

3.164 There has been a range of additional work which has been progressed to support vulnerable children during this period. The Children and Families Social Work and Early Help service are working closely with schools, Targeted Services Leads and other key partners at a cluster level to identify the most vulnerable children, ensuring that there are robust support plans in place. Multi-agency Bronze COVID-19 groups have been established in the East, South and West of the city to provide a strategic response to issues emerging from the clusters. The Children and Families service has also identified vulnerable children who are eligible for technology support (laptops/tablets) under the national scheme and are supporting the roll out of this. Additionally, a new 'Relationship Matters' website recent went live and is a collaboration between 14 local authorities in the Yorkshire and Humber region and forms part of the national Parental Conflict Programme. The website will provide information, advice and resources to parents/carers where conflict is an issue, it will

also signpost to relevant agencies. Children's Centre day care staff also continue to support Leeds Teaching Hospitals to maintain their day care provision for keyworkers.

3.165 In terms of schools, there continues to be extensive liaison with children and families colleagues and schools, providing support where possible and very regular communication from the DCS within the context of the national framework and guidance for schools and local governance of schools. The Leader and Chief Executive also joined a recent call with all head teachers and principals invited, and more than 180 participants. This will be a regular occurrence. This was an opportunity to recognise and say thank you to head teachers and schools for the significant role they are playing during this period in supporting children, especially with our most vulnerable children and the children of key workers. Moreover, the council was also able to provide an update on its approach to the coronavirus outbreak locally as well as to listen to issues raised and to answer any questions. Moving forward, bronze groups have been established, as part of the multi-agency arrangements that are being used in the city. Continued engagement with the wider group of head teachers will continue.

3.166 There was a phased safe reopening of Leeds Household Waste and Recycling Centres for pre-booked appointments only from the 11 May, with brown bin collections set to resume later this month across the city. The council has also outlined proposals to restart its bulky waste collection service during the week commencing May 18. With many households still requiring to self-isolate and shield relatives, the council has also taken the decision to offer this service free of charge whilst these restrictions are in place. Whilst the council will endeavour to offer as many booking slots as is possible in the context of existing resources, this service will be limited, and residents are asked if feasible, to store any waste and continue their efforts to reduce and reuse.

3.167 The importance of parks has been highlighted nationally as well as locally during this crisis as fundamental to the health and wellbeing of every citizen. A number of attractions and facilities have been closed in parks in line with government guidance or regulation, but for the most part parks have remained open. In Leeds there are over 4,000 hectares of public parks and green spaces distributed on over hundreds of sites with over 800 km of public rights of way. Therefore, to enable social distancing and government guidance, there are benefits in encouraging people to use their local parks and green spaces for exercise which can be accessed from their homes and thus distribute people more widely throughout the city. Having considered all of these issues carefully and the fact that the key concern in this situation has to, unquestionably, be the issue of public safety, the decision was taken to close all car parks in parks throughout the city as well as cafes and concessions in parks, playgrounds, outdoor gym equipment, bowling greens, golf courses, fishing, tennis courts and multi-use games areas. People have generally respected these closures. With the new guidance that was issued on the 11 May some of these facilities were re-opened, or plan to re-open, including car parks in parks, cafes and concessions, bowling greens, golf courses, fishing and multi-use games areas. The Arium has also been re-opened for plant and sundry sales.

3.168 Returning safely to public spaces is a key consideration as the city moves in to the recovery phase. Led by a newly formed bronze group there will be a strong focus in developing multi-agency responses to ensure the public can safely access services, amenities and support as well as being able to safely access retail and other

businesses that are permitted to trade and which have a customer interface. The council will work with partners to plan for exiting lockdown with continuing social distance measures in place, ensuring that all relevant community safety issues have been considered and plans in place to manage and mitigate risk. Moreover, the city response will ensure that relevant control and enforcement measures are in place to support members of the public being able to go about their business in a safe manner.

3.169 **Organisational impact:**

3.170 There is a clear framework for the resumption of council services, within the context of the broader multi-agency arrangements where relevant, but it is important to note that we are not planning for a full resumption of services based on pre-coronavirus times. Extensive planning is underway based on what we already know, pending specific guidance from the national context which we will use to inform our local response. A survey based on the five questions above has been sent to heads of service to capture the learning from the changes to our ways of working in recent weeks. An additional wellbeing pulse survey is underway at the time of writing across all staff as a quick check on colleagues' health and wellbeing and to ensure they are receiving the appropriate support as needed; it is anticipated this survey will be rerun at various points in the coming months. HR continue extensive work on deploying staff flexibly to priority areas and TU engagement about health and safety. A particular focus is the use of those staff not currently working but able to work to see if they can help with additional capacity: e.g. wardens to ensure services resume safely.

3.171 Front Line Delivery - Where services cannot be delivered from home we are looking at expanding service resumption, whilst ensuring social distancing. Currently curtailed non-urgent services will not resume unless social distancing can be implemented. Method statements are being developed to ensure the implementation of safe working. The availability of PPE (and associated Government advice) is a key factor in the breadth and speed of service expansion.

3.172 Home working - Overall staff will continue to work from home if their jobs allow, unless a return to office-based activity is central to their role or their domestic circumstances makes home working impractical. As mentioned, Asset Management, Facilities Management and HR are co-ordinating this work. As with front-line delivery, the emphasis will be on health and wellbeing and ensuring that appropriate equipment is provided as required. It is likely the workplace capacity will be restricted to approximately 20% to ensure safe social distancing, so rotas of attendance and staggered starts which seek to avoid peaks in travel will be adopted. The council is working with other major employers across the city to consider in particular the implications for public transport. With regards to the council's own buildings, principles and processes are being established to protect staff and visitors around occupancy, maintaining social distancing and cleaning/ hygiene arrangements.

3.173 HR continue extensive work on deploying staff flexibly to priority areas and Trade Union engagement about health and safety. A particular focus is the use of those staff not currently working but able to work to see if they can help with additional capacity e.g. wardens to ensure services resume safely. Moreover, in anticipation of developments at a national level and as part of considerations of the recovery and renewal phase, the council will remain committed to ensuring any reset accounts for

key factors such as the implementation of safe working for staff and health and wellbeing.

3.174 The council has continued its implementation of the flexible resourcing plan to ensure that critical services can be maintained. The central reallocation pool is continuing to be utilised to support resource deployment enabling effective business continuity both internally and city-wide. There has been a particular focus on supporting staff in vulnerable groups who are working in frontline critical services by matching surplus resource with these roles and a recruitment drive into social care, with volunteers supporting these critical services.

3.175 Arrangements to enable a high proportion of staff to work from home continues to be supported by the Digital and Information Service (DIS) with IT systems running at increased capacity. To further support staff to work remotely during this period the DIS training team have also created a set of virtual learning tools to support online training and development. Additionally, working with partners, the council's IT team has rapidly developed an application to support the online booking system, helping to manage the demand of Household Waste and Recycling Centres, following the recent announcement to open specific sites.

3.176 In terms of the council's management of PPE supplies this is being efficiently distributed to those services where it is required. As highlighted earlier in this report, there remain some challenges as there is continued demand for additional PPE beyond that which PHE has outlined is needed in specific clinical settings. Extensive engagement with trade unions on the complex workforce issues created by the current pandemic including daily meetings regarding PPE challenges continue to ensure maintaining the high standards of health and safety for the council's workforce.

3.177 In terms of maintaining council decision making and scrutiny functions in the current context, the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020 came into force on the 4th April 2020. The Regulations provide flexibility for meetings of Full Council, Executive Board and other committees to be held remotely provided that:

Members in remote attendance must be able at the time of the meeting to;

a) hear, and where practicable see, and be heard and, where practicable, be seen by, the other members in attendance (including where they do so by remote access),
b) hear, and where practicable see, and be heard and, where practicable, be seen by, any members of the public entitled to attend the meeting (including by remote access) in order to exercise a right to speak at the meeting, and
c) be heard and, where practicable, be seen by any other members of the public attending the meeting by whatever means (including remote access)

3.178 In order to respond to the practical challenges provided by the Regulation, joint work was undertaken by Democratic Services, DIS and Facilities Management which has enabled remote meetings of Full Council and Executive Board to take place. In addition during April each Scrutiny Board Chair has been meeting regularly with

Directors and Executive Members to review the COVID-19 response and, during May these arrangements will be extended so that, on a fortnightly basis, all Boards Members will be engaged (as a working group) in those briefings. Community Committees have now also now started to meet remotely as advisory working groups.

3.179 Formal Remote Meeting arrangements are resource intensive and currently require separate teams to; manage the webcast (to provide the public access element); manage the virtual meeting space, and; provide governance/clerking to the meeting. Work is nearing completion on a programme of formal remote meetings of Executive Board, Scrutiny Boards, Plans Panels and Corporate Governance and Audit Committee, initially for the period until the end of July. Work is also being progressed by DIS and Democratic Services to explore arrangements to more efficiently support and facilitate these meetings both now and beyond the current lock down (where all participants access meetings remotely) to a potential future scenario where some Members (and other participants) might physically attend a Meeting (observing correct social distancing precautions) with other Members (and the public) attending/accessing the meeting remotely.

3.180 The financial impact of coronavirus is also detailed in a separate report on the agenda of this Board meeting.

3.181 **Media and communications**:

3.182 Communications during this pandemic has been key given the fast changing nature of the situation and the reliance on everyone to play their part. Councillors, staff, MPs and partners continue to regular updates of the national and local activity in relation to the Coronavirus response and recovery. To support their community role during this incident, councillors have received regular updates to ensure that they have the latest local and national information to fulfil their role.

3.183 The multi-agency communications group continues to inform messaging supported by the broader council and partners. Business, partners, head teachers and workforce communications continue to be updated with extensive frequently asked questions issued. As mentioned, engagement with trade union colleagues have continued throughout this period.

3.184 The council's dedicated webpage related to coronavirus is regularly updated reflecting any developments at national and local level, with a total of 190k visits. The website includes key information for the public and businesses in relation to the council and city response to the coronavirus outbreak and the various support available (the website can be found here).

3.185 Social media advertising has been used for key messages so that it is available in the language of the user and there continues to be translated material of key documents into languages where we have the most users. Infographics are being used to help communicate clearer.

3.186 In order to further increase media engagement and to answer specific questions about the councils approach to the outbreak, regular press briefings are now held on a weekly basis.

**Corporate considerations**

## 4. Consultation and engagement

4.1 Extensive engagement continues between services within the council, with partners, with elected members and with the public. It has not always been possible to engage in the normal way about service changes as there has been no choice about many of the changes to ensure compliance with national guidance. Ward members have played a key role in engaging the public, particularly in encouraging neighbourliness and volunteering to help the vulnerable. We have endeavoured to keep people up to date with developments as best we can. Engagement with stakeholders has continued and in many cases been strengthened with the context of what we have had to manage during this incident. Regular written updates to partners, weekly messages to the public, regular thank you notes to staff and calls with MPs, head teachers, and businesses.

## 5. Equality and diversity / cohesion and integration

5.1 These considerations are already an implicit part of the planning, particularly given the nature of the incident and this will continue, for example with prioritisation of services for vulnerable people and monitoring of potential community tensions and the impact on inequalities. Snapshot data on this has been provided regularly in the councillor/MP updates. Work is ongoing to specifically review inequalities in targeted communities and equality and diversity is built into the consideration of all citizens and communities work including for example, appropriate food provision and faith community engagement.

## 6. Council policies and the Best Council Plan

6.1 In terms of the Best Council Plan, adaptations are being made to the version that was agreed at February Full Council to ensure that the COVID context is accurately captured, then will be published soon. We plan a further, more fundamental review of the suite of city strategies later in the year when we know more. Here is a summary of some of the issues that will feature in the coming months.

6.2 Recognising this is a complex and long lasting recovery, maintaining clarity of focus will be crucial so that we have all potential capacity in the city, including the public, engaged and playing their role. Retaining the ambitions of best city, with a strong economy that is compassionate, will be important so that priorities, resources and relationships are guided by that shared ambition and the values. We want to retain the overriding priority of tackling poverty and inequalities, underpinned by our three pillars: inclusive growth; health and wellbeing; and climate change, which are even more relevant now, and the links between them even more critical.

6.3 In terms of Inclusive Growth, the economic impact has been instantaneous, large parts of our economy are in shutdown, many businesses are facing severe pressure, with grave concerns regarding business closures and redundancies. The crisis has

compounded deep-rooted inequalities, with young people, and low earners being most affected to date as they are most prevalent in the hardest hit sectors. Many families are struggling with uncertainty and the potential of mounting debt. The longer the current measures are in place the greater the economic impact, with difficult decisions regarding interim measures, specifically how to ease pressure on those individuals, communities and businesses most affected, who in many cases are not at the front of the queue in any return to normality.

6.4 Health and Wellbeing has been the primary focus of our collective response to date, and tragic though the crisis is, our worst fears have not yet been realised. However, significant concerns remain, regarding the most vulnerable, specifically those in care homes; the supply of PPE; and, the speed at which a more systematic approach to testing and contact tracing can be introduced and accelerated. The health and social care response remains the top priority, however, we are already seeing evidence of the wider health impacts of the crisis, with the drop in numbers of other patients presenting themselves and what this might mean, and the potential impact on mental health of the current measures. The longer-term economic fallout is likely to have an adverse impact on already significant health inequalities, with those individuals and communities at most disadvantage hit hardest.

6.5 The impact on our response to Climate Emergency is more complex, but presents significant opportunities presented by the reduction in travel and encouraging more active travel. However, the practicalities of re-booting public transport whilst maintaining social distancing will require careful planning and adjusted behaviour from commuters. In the longer term, it will be important to resist the very strong temptation to simply resume past behaviours with all the associated environmental consequences. As we move out of lockdown and towards a longer lasting new "normal" we will need to reset our carbon reduction ambition for the city. This could encompass promoting more sustainable and healthy movement of people; new ways of working, adopting digital technology and home working; emphasising the value of green spaces and reviewing the role of special planning in pursuing low carbon; influencing consumer behaviour and increasing recycling.

7. <u>Climate Emergency</u>

7.1 We are continuing to review implications in relation to the climate emergency as the situation develops. The current focus on the practicalities of how people will commute when they return to work whilst maintaining social distancing requires careful planning and adjusted habits from commuters, but also provides an opportunity to increase active travel across the city. As we develop our recovery plans these will incorporate the promotion of more sustainable and healthy movement of people; exploring new ways of working, adopting digital technology and home working; emphasising the value of green spaces and local community as well as looking to focus on green investments.

8. **Resources, procurement and value for money**

8.1 Given the significance of the financial implications of coronavirus, there is a separate and more detailed report is included on the agenda for this meeting.

9. **Legal implications, access to information, and call-in**

9.1 With the agreement of the Chair, given the significance and scale of this issue, it is appropriate for the Board to receive an update at this meeting. However, this report is coming to Executive Board as a late paper due to the fast paced nature of developments of this issue and in order to ensure Board Members receive the most up to date information as possible. A further verbal update on developments since the publication of this report will be provided at the Board meeting.

## 10. Risk management

10.1 The risks related to coronavirus referenced throughout this report will continue to be monitored through the council's existing risk management processes. For example under two of the main standing risks of "Major incident in the city" and "Major Business continuity issue for the council". Other corporate risks, such as those relating to the council's budget and the Leeds economy have also been updated to reflect the impact of the outbreak. More specific risks relating to coronavirus are being managed through the Silver Groups, with the more significant ones being escalated onto the corporate coronavirus risk document seen in annex E. The rating of this risk is difficult given the uncertainty, in light of that, a cautious approach is taken for the target rating.

## 11. Conclusions

11.1 This report provides an update on the ongoing progress made by the council working with partners and communities in response to the unprecedented COVID-19 pandemic. As the gradual lifting of lockdown and national recovery strategy has been articulated and will become the new normal, there remain a series of challenges which will require harnessing the strong multi-agency relationships built as well strong engagement with wider partners, businesses, third sector, elected members, the public and communities across the city.

11.2 This report further details the rationale and immediate activity of the council as the recovery phase approach is developed and the immediate challenge of lifting the lockdown safely in Leeds, reflected in the approach described, with the infographic being used to help promote the right behaviours for the city to stay safe and safe lives.

11.3 The council's continued focus will be maintaining the response to key issues, especially on care homes, complemented with progressing preparations for recovery consistent with the national approach, leading to safely lifting lockdown. A key feature of this next phase will be contact tracing, linked to effective testing, and effective management of local outbreaks with clear governance.

## 12. Recommendations

12.1 Executive Board is requested to:

1) Note the updated national context and local response to the coronavirus (COVID-19) outbreak.
2) Agree the updated Response and Recovery plan update, including the updated aims and objectives.
3) Agree the approach and messaging for running a safe city.

4) Use this paper as context for the more detailed paper on the financial implications of coronavirus for the council

## 13. Background documents[1]

13.1 None.

## 14. Appendices:

Annex A: West Yorkshire Resilience Forum COVID-19 Epidemic Reset, Rebuild Strategy

Annex B: Leeds Strategic Response and Recovery Plan – coronavirus (COVID-19)

Annex C: Leeds Strategic Coordinating Group (SCG Gold) Weekly Dashboard 12 May

Annex D: Coronavirus infographic – Recovery Approach

Annex E: Corporate risk LCC 5: Coronavirus pandemic (COVID-19) – May 2020

[1] The background documents listed in this section are available to download from the council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

**West Yorkshire Resilience Forum COVID-19 Epidemic**
**Reset, Rebuild Strategy – 15th May 2020 onwards**

## 1. Aim and objectives

On the 20th March the West Yorkshire Local Resilience Forum (LRF) declared the COVID-19 outbreak a "major incident" under the Civil Contingencies Act 2004. Since this declaration, the LRF's Strategic Co-ordination Group (SCG) have held daily calls with representation from all Category 1 responders (Local Authorities, NHS, Police, Fire and Rescue Service, Ambulance Service and Environment Agency) and Category 2 responders (utility companies, transport companies) and wider partners.

The management of the epidemic is dynamic, ever–changing, complex and systemic. The response required is global; international, national, regional, local, community, family and individual. It is clear, therefore, that all agencies, strategic partners and communities will continue responding to the impacts of COVID-19, while simultaneously transitioning to a more dynamic (alert level based) model.

Tackling the epidemic will be long-term; for the time being we are *living with Covid19.* Our strategy will require us to work in ways we had not envisaged before until an effective vaccine or treatment has been established.

The LRF SCG has recognised three phases to the work, which will run concurrently;

1. Mitigating the initial impact of the coronavirus epidemic on the communities of West Yorkshire.
2. Managing the easing of lockdown restrictions whilst still living with COVID-19
3. Laying the foundations for future economic and community recovery

It is recognised that working on and moving through these phases will be significantly affected by any rise in rates of infection, hospital admissions and/or mortalities, subsequently leading to a future tightening of lockdown restrictions. We will seek to be guided by evidence from the R rate, from our local places, from national and international research and best practice.

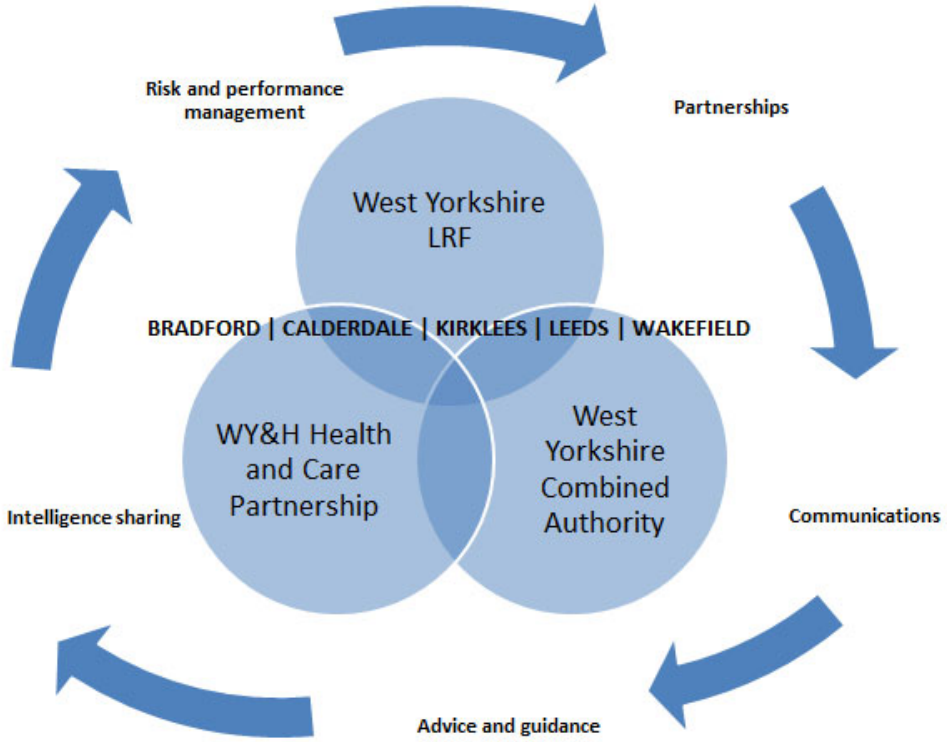
The overarching aim of the West Yorkshire Resilience Forum is to **preserve life and relieve suffering, support those most vulnerable, and the health and social care system** through collaboration, co-ordination and communication and by following the principal objectives;

- Minimise infection and mortality rates by protecting West Yorkshire's communities against the health and wider consequences of the coronavirus epidemic.
- Collaborate to create safe communities, safe transport, safe education, safe public spaces and safe work places.
- Support isolated people and encourage community resilience, particularly those who are shielding or experiencing hardship.
- Support activity to delay the spread of the virus locally and proactively managing cases to reduce further spread.
- Recognise and address the impact of the epidemic on the widening inequalities gap.

- Enable greater economic activity in line with national guidance and advice.
- Support delivery of the national strategy; providing a more local context, whilst at the same time positively challenging and influencing decision making to create pragmatic solutions for West Yorkshire.

## 2. How we will deliver against our objectives;

There are a number of West Yorkshire-wide partnerships that will have a contribution to make and a significant impact on how we effectively manage the epidemic. The West Yorkshire Local Resilience Forum (LRF), the West Yorkshire and Harrogate Health and Care Partnership and West Yorkshire Combined Authority (especially the focus on economic recovery) are particularly relevant. Localities will rightly have a different and nuanced approach for their communities.




We will continue to consider, as we have throughout the COVID-19 pandemic, the following;

- What is best done at scale – using the vast array of organisations contributing to partnerships?
- What can be done best at "place" level vs what best done at a West Yorkshire level? Civil Contingencies Act 2004 assumes subsidiarity.
- How can we most effectively influence national debate?
- What is best done together be that;
    - Thematic delivery
    - Risk and performance management or

- Cross cutting activity such as intelligence sharing, advice and guidance and communications

## 3. Current priorities

While working within the context of promoting messaging on staying at home, working from home where possible, acting responsibly and following social distancing guidelines at all times, the West Yorkshire Resilience Forum recognise the significant role that test, trace and contain will play in the enabling of the following priorities;

- Hunting down the virus through proactive Test, Track and Contain and gearing up for the future roll out of a vaccination scheme.
- Safe communities – supporting those that need shielding, the most vulnerable and the newly vulnerable. Supporting and enhancing the community and voluntary sector. Actively working to reduce (or at least not widen) the equalities gap. Health and social care activity and effective mortality planning.
- Safe transport – accessible and safe public transport, modal shift to working from home, walking and cycling and taking the opportunity for carbon reduction.
- Safe education – the reopening of nurseries, school, colleges and universities, vital to support the growth of economic activity in the region in the period prior to an effective vaccination or treatment being developed.
- Safe public spaces – towns and city centres, parks and managed open spaces, shops and retail spaces, land and the countryside.
- Safe work places – shared advice and guidance, support for local businesses as well as our own organisations, sufficient personal protective equipment.

The priorities are interlinked and only effectively delivered via many partnerships and organisations.

## 4. Delivery

### a. Thematic approach

The thematic approach to delivering our priorities at this stage of the epidemic will be multi-level and delivered in partnership.

The Safe communities' priority will most often be a partnership between localities and where economies of scale are useful at the West Yorkshire Resilience Forum level. Examples of this would include where a collective understanding of the issues, to support dialogue with central government is more effective than localities can muster on their own. Test, trace, contain activity will be delivered through Public Health England, with an important link into Directors of Public Health in localities who will have a responsibility for a locality plan and again important economies of scale can be gained from having collective guidance across West Yorkshire. This will be overseen by Supporting and enhancing the community and voluntary sector would be a priority for localities. Health and social care activity is likely best done across West Yorkshire and Harrogate Health and Care Partnership and effective mortality planning with West Yorkshire Resilience Forum oversight. Each Director of Adult Social Services has responsibility to complete a Resilience Plan for social care to manage and mitigate impacts for those receiving services.

The Safe transport priority is already a key issue for the West Yorkshire Resilience Forum with active attendance by West Yorkshire Combined Authority Transport Services. All aspects of the priority are delivered through the Authority with collaboration from all the localities. Support from the Resilience Forum is offered, where additional benefit can be gained.

The Safe education priority will be a significant factor in restarting economic activity in West Yorkshire. Local Authorities will respond to and share expected advice and guidance to support the safe and timely re-opening of schools potentially as early as 1st June. This will ensure that schools reopen in the region when it is safe to do so, through a phased approach.

The Safe public spaces priority has a number of opportunities. Firstly there are rafts of organisations who attend the Resilience Forum who are also significant land owners. Some form of collaboration, shared good practice and collective communication is useful. West Yorkshire Police have responsibilities for order and Local Authorities similar and additional responsibilities, particularly relevant in our towns and city centres. Localities have further responsivities for parks and managed open spaces,

Safe work places – shared advice and guidance and sufficient supply of Personal Protective Equipment for all the organisations that are members of the Resilience Forum is a useful function for it to support. Support for local businesses is a responsibility for localities and wider economic recovery best delivered through the Combined Authority.

b. Communications and engagement

Communications will play a leading role in the next stages of the work of the Resilience Forum. The West Yorkshire Resilience Forum Communications Cell will pull together partner's communications strategies to find commonalities and ensure regional and district communications are consistent across West Yorkshire.

The easing of lockdown provides an opportunity to promote messaging in public spaces and on public transport. The West Yorkshire Resilience Forum Communications Cell is taking an active approach to this.

c. Governance, roles and responsibilities: LRF cell/subgroup structure

**NB: to be revised and developed referencing an Appendix One map**

d. Performance and risk management

Risk and performance management is important with any incident. Both risk and performance management will thus still be a fundamental part of governance moving forward. An incident risk register and performance framework will be separate to the strategy as live documents.

Risks and issues have been highlighted and mitigated wherever possible. Examples include the need and supply of PPE, difficulty with the data about shielded individuals and that guidance has lagged behind government announcements. These risks have be logged and indeed escalated to colleagues in central government, when necessary. Future risks may include;

- Uneven delivery of test, tracing, contain

- Lower levels of compliance
- Inability to enforce
- R rises above 1

Objectives have and will continue to be measured against a number of indicators. Moving forward a wide-view comprehensive set of measures will be developed to allow tracking of key features. We will want to know where bottle necks and pressure points occur at the same time as making sure that things like the R rate stay below 1. To be comprehensive this set of measures will need to be delivered from organisations across the LRF. For examples will include a way of tracking cases, testing, excess deaths, outbreaks, PPE stocks etc. and also wider performance measures including schooling, transport, safe spaces and economic activity.

e. Review

Due to the dynamism of the situation in which the West Yorkshire Resilience Forum is operating, we recognise that this strategy will be subject to continuous review and routinely every two weeks.

Annex B

## LEEDS STRATEGIC RESPONSE & RECOVERY PLAN – Coronavirus (COVID-19)

This plan provides a framework for response and recovery to the coronavirus (COVID-19) pandemic, enabling the council and city to be as prepared as possible given the unprecedented challenges, rapidly changing context, the resources and information available. The multi-agency arrangements drive delivery of this plan, combined with the efforts of individual organisations and the community more broadly. It is set within the context of the government's strategy to tackle coronavirus and within the context of the West Yorkshire Local Resilience Forum (WYLRF), the West Yorkshire Health Resilience Partnership (WYHRP) and the West Yorkshire Combined Authority.

In overall terms, we can view the next phases as follows:
- Responding to the virus and its effects, safely lifting lockdown
- Living with the virus in the population, where social distancing has to be maintained
- A new normal, most likely once a vaccination is available

The themes of the Response and Recovery plan and multi-agency arrangements to drive these are maintained as follows:
- Health and social care
- Infrastructure and supplies
- Business and economic impact
- Citizens and communities
- Organisational impact; and
- Media and communications



**Aim:** The city's response and recovery will be driven by our shared ambition and values, with the overriding priority of tackling poverty and inequalities through a combination of a strong economy and a compassionate city.

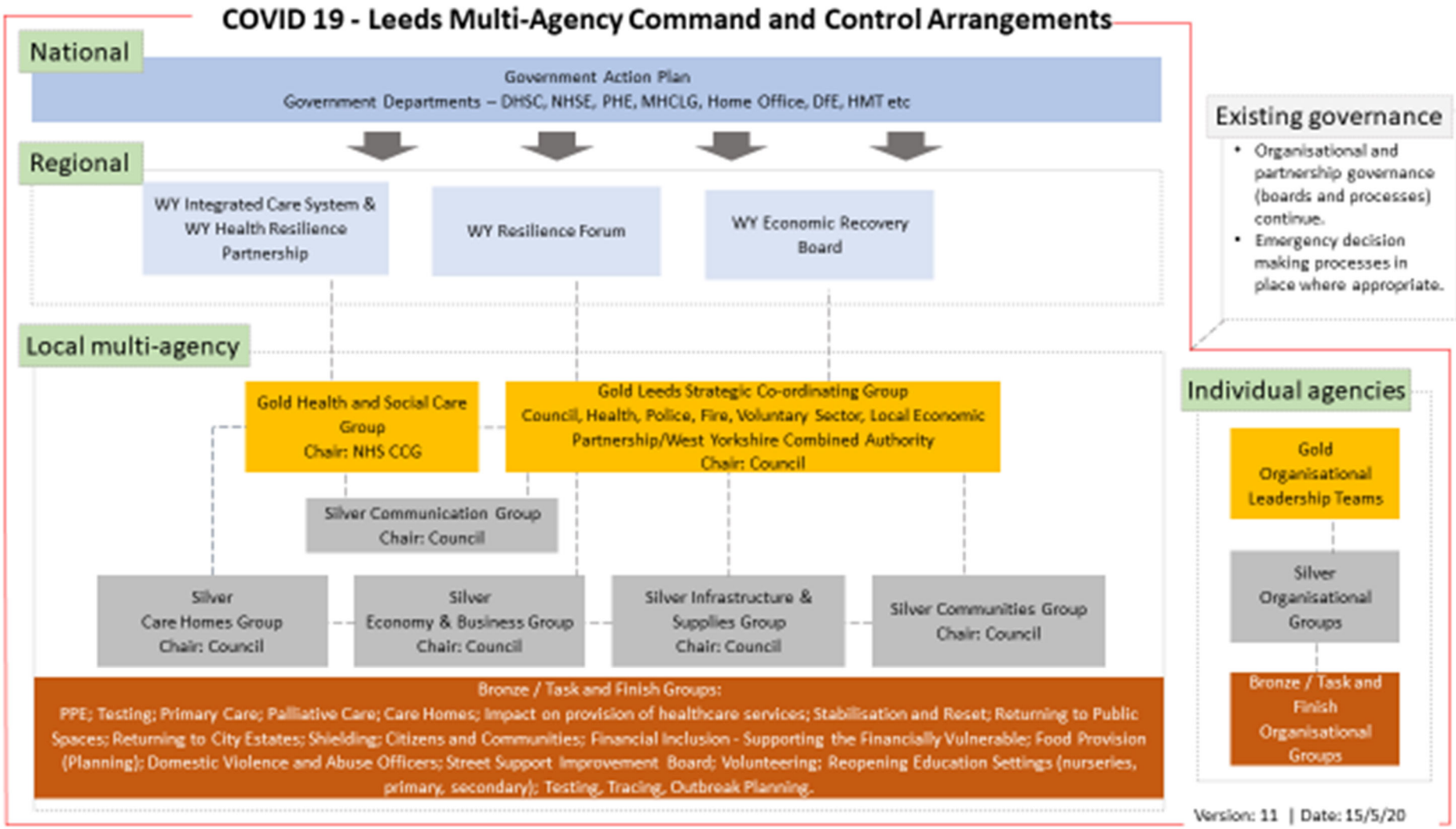
**Objectives:**

- Continue to minimise the effect of the outbreak on the health and wellbeing of the city, especially the most vulnerable, and integrating services to achieve this;
- Ensure the provision of essential services, focusing on individuals, families, communities and businesses most affected, whilst encouraging communities to provide support themselves and be actively engaged in the part they can play;
- Work to resume economic and social activity safely and effectively with social distancing measures in place, in line with national guidance and advice;
- Begin to focus on recovery and renewal underpinned by our City Ambition's three pillars - Inclusive Growth, Health and Wellbeing and Climate Change.

Whilst social distancing remains key for public health reasons, the overall framework that we are using to lift lockdown is to test, trace and manage outbreaks to enable:

- **Safe travel** ensuring the safe use of highways and public transport and encouraging active travel where possible.
- **Safe public spaces** with physical distancing in communities, district centres and the city centre.
- **Safe delivery of services** including health and social care, and other public services.
- **Safe education** as more children and young people return to schools, colleges and nurseries.

- **Safe working** with physical distancing in workplaces and coordination between large employers to avoid peaks of movement.



| Item no. | Action | Officer lead(s) | Status / Comments |
|---|---|---|---|
| **1. Health & social care** | | | |
| 1.1 | Ensuring effective liaison and support between the Council, Local NHS Partners and the West Yorkshire Local Health Resilience Partnership (LHRP), to provide an effective, co-ordinated multi-agency response to Coronavirus (COVID-19), including readiness of the health and social care system, from acute to community, to deal with the anticipated pressures in the system effectively. | **Health & Social Care Gold** (Victoria Eaton, Julian Hartley, Cath Roff, Tim Ryley) | • Health and Social Care Gold command has been established. It encompasses all aspects of the system, chaired by the CCG Accountable Officer to oversee the local management and system co-ordination of the pandemic. It has a clear focus on ensuring hospitals have sufficient intensive care capacity whilst maintaining access for continuing, urgent and primary care. Command arrangements include a weekly Silver group and seven weekly Bronze groups.<br>• Bronze Groups have been rationalised to reflect some have finished their tasks. Remaining groups are focusing on the priority areas that will continue to have an impact across the system, as follows:<br>o Care Homes<br>o Personal Protective Equipment (PPE)<br>o Shielding<br>o Testing and Contract Tracing<br>o Frailty and End of Life<br>o Primary Care<br>o Impact on Provision of Healthcare Services and<br>o Stabilisation and Reset<br>• A wide range of both formal and informal boards and groups exist across the city that can escalate matters to Gold (for decision) and/or may be asked by Gold to resolve specific issues or make proposals to mitigate identified risks.<br>• System continuing to liaise with Public Health England (PHE) and West Yorkshire Health Resilience Partnership (LHRP)<br>• Healthwatch Leeds (HWL) has had an active role in Leeds' Command arrangements in response to the COVID-19 pandemic – and is represented in the Health and Care Gold Command arrangements.<br>• Since early April 2020, HWL has been running a COVID-19 listening campaign; producing a weekly report with insight into how it is feeling for people – particularly those communities in Leeds with the |

| | | | |
|---|---|---|---|
| | | | greatest health inequalities. As part of the overall campaign, a 'Question of the fortnight' has been running, focusing on a range of service issues, including:<br>o The move to digital service provision;<br>o People's mental health and access to mental health services; and,<br>o Information about COVID-19 provision.<br>• Public Health continue to work pro-actively on surveillance, prevention and control of COVID 19 in Leeds. This work is supporting the health and care system to safely manage COVID 19 outbreaks in the community and to manage system flow.<br>• The Public Health intelligence team continues to provide specialist support to enable detailed understanding of the current and future impact of COVID 19 on the city, enabling the system to provide a timely and effective response and to inform preparedness planning to meet changing demands. There is a specific focus upon understanding how Covid 19 affects different population groups - how the virus contributes to and compounds heath inequalities in the city. The Public Health intelligence team is reviewing information about deaths provided by LTHT and local registrars.<br>• The team is actively pursuing intelligence about the location of cases and hotspots, which will be important information to have in being able to develop contact tracing, particularly in light of potential easing of restrictions.<br>• Public Health have produced a COVID - 19 Health Inequalities report. It sets out the effects of COVID 19 on key population groups and on areas of deprivation. The report uses national intelligence about COVID 19 and combines this with what we know locally. This evidence based report is also being combined with the equality report compiled by the Communities directorate. Recommendations will be shared across LCC and with the health and social care system.<br>• Public Health is ensuring consistent national public health messages are being used locally. Promoting good mental health advice for the |

| | | | |
|---|---|---|---|
| | | | general population (including children & young people) has been developed along with targeted messages for vulnerable groups<br>• Testing for all health and care staff continues under leadership from the Director of Public Health.<br>• Eligibility criteria for testing has been expanded from health and social care staff only, to include over 65s, and care home staff / residents with symptoms or those who are asymptomatic .<br>• Drive-through testing site established at Temple Green for NHS and key workers. Testing capacity continues to increase. The take up from staff in Leeds has been good and now stands at 1,000 slots per day.<br>• LTHT staff continue to be tested through the pathology laboratory at the LGI.<br>• LTHT testing increasing with patients admitted being tested and tests are also being sent out to care homes.<br>• Effective partnership working at a local level has helped to identify and develop local solutions to issues related to care homes. This includes: utilising local resources in order to improve the time taken for swabs to be delivered and received from care homes during the initial outbreak testing phase; better communication of the results to primary care colleagues, and the implementation of testing for residents in community care beds.<br>• A national booking system is in place for employers and /or staff to book a test or to order home testing kits. A new web portal is also being set up by the Department of Health and Social Care. This will enable all care home residents and staff to be tested together.<br>• Local turnaround times for staff tests at LTHT is around 24 hours and at Temple Green around 48 hours. |

| | | | |
|---|---|---|---|
| | | | • Early discussions are under way to ensure that the national contact tracing programme works for Leeds and delivers for the local system. Leeds has a strong record of effective outbreak planning and response across the health and care system, which puts the city in a strong position to take this work forward.<br>• A detailed action plan has been developed focusing on the overall support for care homes, against the following objectives:<br>o Objective 1: To minimise infection and mortality levels across our care homes and supported living schemes<br>o Objective 2: Support the well-being of care home residents<br>o Objective 3: Support the well-being of care home staff<br>o Objective 4: Ensure safe admission to care homes<br>o Objective 5: To respond in a timely way to care homes experiencing difficulties<br>o Objective 6: Support care homes with simple and timely information<br>• Since the beginning of March we have provided an additional 1,472 packages of support to people, either in their own homes of in a care home<br>• The Health and Care Gold Command Group has agreed a revised Personal Protective Equipment (PPE) position statement for Leeds care home and community staff. This updated position statement for Leeds, uses the most recent national guidance released by PHE on PPE use for domiciliary care and in care homes. Details continue to be disseminated to partners by the PPE bronze group.<br>• Public Health and colleagues in adults and health have also developed draft guidance for the VAL volunteer schemes.<br>• Public Health has also been working closely with CCG colleagues to identify and address the non-COVID health issues that have arisen |

| | | | |
|---|---|---|---|
| | | | over the last few months to ensure the impact on people and health inequalities is minimised.<br>• Extensive changes have been made through partnership working across the local health and care system to cope with the pandemic, including:<br>o Significantly increasing LTHT's intensive care capacity and isolate this for COVID positive patients.<br>o Converting spaces (such as operating theatres) to become critical care facilities<br>o Reducing the number of elective (planned) operations to limit the number of people who will need intensive care in recovery from theatre.<br>o Limiting complex operations to reduce the risk for patients who could be immunocompromised after surgery and also reduce the risk of COVID-19 infections acquired in hospital.<br>o Changing the nature of GP interaction, shifting from face-to-face service delivery to a model that includes extensive triage and digital / telephone based patient consultations.<br>o Extensive social care changes to support hospital discharges implemented on 18th March 2020, including an additional 120 step-down beds commissioned across the city; and ongoing work to support discharge for Older People's Mental Health Services. Key data demonstrates rapid progress with 165 patients in the bed base for 21 days or longer, compared to 487 patients in January 2020, with 116 people supported to move (by 9th April).<br>o 7-day social work cover in place to support hospital discharge and throughput from step down beds and cover for COVID advice line since 3rd April<br>o Talking Points (face to face advice offer ) suspended on 18th March , replaced by responsive telephone support and |

| | | | |
|---|---|---|---|
| | | | prioritisation of home visits within Social work and occupational therapy services<br>o Additional support continues to be offered to people no longer able to access day services from 18th March 2020<br>o Guidance developed to support people who lack capacity regards decision to adhere to social isolation rules<br>o Extensive workforce changes to support the actions taken, with continued communications, effective use of ICT, provision of PPE and associated guidance for the use of PPE<br>• COVID-19 support line delivered through St Gemma's and Wheatfields Hospices is now available to anyone with family members or friends that are critically ill or have died from any illness during COVID-19.<br>• The West Yorkshire Nightingale Hospital in Harrogate has been completed and opened on 23 April 2020.<br>o The hospital has passed approval testing and the site is being maintained.<br>o The hospital is ready to receive critical care patients and is available for use if needed as an overflow facility for critical care only.<br>o The management team for the hospital have returned to their respective host Trusts and staff who have been trained are back at their usual places of work.<br>o Staff will be mobilised if overall capacity requires the use of the facility.<br>o LTHT experienced a peak of patients between 9-17 April and has seen a gradual reduction since then; however the Trust still has a high number of COVID-19 positive patients over 100 who are receiving care within the Trust.<br>o Actions taken have resulted in good capacity and sufficient well-trained staff at LTHT to provide high quality, safe care for |

| | | | |
|---|---|---|---|
| | | | the number of COVID positive patients who have been admitted.<br>o LTHT continues to have the ability to cope with further increases in demand and transfer of patients from smaller NHS Trusts across the region.<br>• At the time of writing, LTHT has:<br>o Had 887 cumulative inpatients who have tested COVID-19 positive.<br>o Tested 1372 positive patients who have either not been admitted to hospital or have been admitted at other hospitals.<br>• In relation to Leeds specific data, all deaths registered in the period 27 March to 14 May 2020, there were 525 deaths which were identified as relating to COVID-19. In regard to where those people died, 296 (56%) died in a hospital setting, 200 (38%) died in care homes and 29 (6%) died in a hospice or at home. Of all deaths registered since the 27 March 2020 when we received the first suspected COVID-19 related death registration, 33% of all deaths registered have been identified as COVID-19 related.<br>• Continued Public Health support for the GP Confederation and Primary Care Networks with practical support and advice in relation to staying healthy and self-care for both the shielded group and other people at high risk,<br>• Ensuring rough sleepers placed into emergency accommodation continue to, or start to receive support and treatment for drug and alcohol issues.<br>• Significant work with providers to ensure their readiness and engagement.<br>• Written to 12,500 unpaid carers to ensure they are clear about routes to help if needed. |

| | | | |
|---|---|---|---|
| | | | • Close links with Citizens and Communities group continues to ensure effective support from communities, volunteers and Third Sector Leeds<br>• Reorienting volunteering work contracts with the Third sector to enable them to provide this service.<br>• Contribution to the Council's wider response to emergency food provision, including providing information and advice to ensure appropriate support and referrals, influencing the food offer to ensure healthy balanced food availability and developing support resources around food safety, healthy eating, managing waste and recipes.<br>• The PPE challenges facing local services across the system continue to be raised via national channels. See section 2.3<br>• Care homes remain a significant concern for the city, particularly in light of continuing problems with securing PPE supplies. There have been a number of care homes with confirmed cases/outbreaks in Leeds.<br>• The Infection Control team continues to contact all Leeds care homes daily to provide regular support. As a result, the Council is remains confident that the data is highly accurate, and that reporting practices continue to be consistent.<br>• Developing communications plan to support moving towards steady-state COVID activity and escalation of planned activity in phases to cover urgent and cancer ops, long waits and then routine activity<br>• Nationally, routine dental appointments are not taking place and patients in need of urgent dental care should not visit (i.e. walk in) their regular NHS dentist, nor should they visit A&E. |

| | | | |
|---|---|---|---|
| | | | • All NHS Dental practices and NHS 111 remain open and accessible to patients to provide urgent telephone advice and a triage service – referred to as a Triple A service (Advise, Analgesia, Antibiotics). NHS 111 also provides an Out of Hours service.<br>• Urgent Dental Care in Leeds is accessed via NHS 111. Treatment is provided 7-days per week, 8am – 8pm. Additional Urgent Dental Care capacity is being created across Leeds that will allow triaged patients to access urgent dental care.<br>• Subject to the availability of enhanced PPE, Urgent Dental Care Centres are being established in a minimum of 10 locations across Leeds. |
| 1.2 | Focus on Phase 2 of the COVID-19 response; considering how all local NHS systems and organisations reinstate non-COVID-19 urgent services as soon as possible over the following six weeks (from 29 April 2020). | | • Leeds Health and Social Care system continues with the command and control function, as required at national and regional level as part of the Emergency Prevention, Preparedness and Response (EPPR) approach, but locally the focus is shifting firmly forward into Living with COVID-19 phase. As such, there will be a need to strike the balance between:<br>o Stabilisation and resetting<br>o Re-Opening services in a safe and co-ordinated way, at the appropriate time<br>o Planning for potential further COVID-19 and winter surges<br>• Work led by Leeds CCG focussing on the wider impacts of COVID, including post COVID rehabilitation; impact on urgent non-COVID related conditions; impact of interrupted care on people with long term conditions; and mental health and physical health impacts of the pandemic. |

| | | | |
|---|---|---|---|
| | | | • Amongst other actions being taken forward, Leeds Teaching Hospitals NHS Trust is implementing a phased response to reinstate non-COVID-19 services. This will focus on:<br>o reviewing clinical priorities across all waiting lists<br>o repurposing areas from providing critical care to providing elective operations<br>o moving staff back from COVID-19 care to their clinical specialty<br>o restarting elective activity<br>o increasing virtual patient appointments<br>o increasing testing of staff and patients<br>o increasing diagnostic activity<br>o increasing the use of the independent sector for surgery<br>• A&E attendances and referrals from primary care expected to increase compared to April 2020.<br>• NHS Leeds has published a useful traffic light guide for parents who have an unwell child; and West Yorkshire Police continue to fully support anyone who is concerned about their own or someone else's safety and wellbeing and continue to encourage people to call them for help if/when people are in imminent danger.<br>• Leeds 0-19 Public Health Integrated Nursing Service (health visiting and school nursing) continue to provide antenatal and birth visits to all families. The first line of contact with families is currently via telephone or video-call; however home visits (with appropriate use of PPE) continue where there are concerns. Working closely with Children's Centres and children's social care the service continues to offer additional 'universal plus' contacts and contacts with vulnerable families where required. |

| | | | |
|---|---|---|---|
| 1.3 | Prepare for outbreak planning as lockdown restrictions are eased to ensure integration between national and local system. | **Victoria Eaton/Mariana Pexton** | • Draw on extensive planning and exercising done on outbreak planning in the city and adapt for the specific nature of COVID-19.<br>• Be involved in national and regional discussions about how this will work in practice to balance the health and economy issues, have clear communications with the public and good governance.<br>• Be proactive about data flows from national systems and engage all settings for potential outbreaks.<br>• The We Care Academy have supported 43 people so far into employment with a further 38 people either on work experience placements with guaranteed job interview or awaiting pre-employment checks.<br>• |
| **2. Infrastructure and supplies impact** | | | |
| 2.1 | Work with relevant authorities and agencies to assess and respond to disruption to key infrastructure such as public transport. | **Gary Bartlett** | • Liaison with the West Yorkshire Combined Authority (WYCA) to continue to review changes to Bus and Rail services, link on communications about this.<br>• Updated advice and guidance made available to bus and rail passengers and communicated through all channels. Service frequencies are set to increase on rail and bus but social distancing will adversely limit capacity.<br>• Work to focus on key worker transport, including for Nightingale<br>• Support where needed for pressure points on transport<br>• Introduced first wave of social distancing (SD) measures in the city centre.<br>• Consultation has been completed on the A65 orcas and wand scheme to improve cycling facilities and encourage safe travel. This is part of a package of measures to respond to the constraints on public transport capacity by the implementation of social distancing.<br>• Completed a city wide review of local centres to identify possible interventions |

| | | | |
|---|---|---|---|
| | | | • Continue to work with partners on Silver Group to understand and collate issues and to identify appropriate courses of action<br>• Working with partner organisations on Temple Green testing facility and additional testing facilities, Nightingale provision and other estate as part of the COVID emergency<br>• Providing support for the delivery of PPE across the city<br>• Procuring hundreds of metres of appropriate barriers for further active travel interventions<br>• Commence a public consultation on Commonplace to identify problem areas and opportunities for active travel<br>• Ongoing work supporting the HWRCs<br>• The approach to staff WFH and those returning to the office is delivered through the 'mobilise and energise programme' which focuses on two key areas of:<br>o Continued home working through the theme 'Working from Home First but Better' – plans will be accelerated to improve productivity and support staff wellbeing through three key areas of equipment, training and service transformation through digitisation<br>o 'In Place' which is adapting and accelerating the use of our buildings to enhance wellbeing and productivity for our colleagues, customers and partner.<br>• A bronze structure will coordinate these working areas.<br>• The reopening of buildings will be in line with the COVID alert system published by national government.<br>• The priority is to ensure that where people are returning to the office, this is managed to make sure that social distancing can be maintained. |
| 2.2 | Assess the possible impact on key supply chains and required actions e.g. Catering Services (e.g. school meals), Cleaning services | **Sarah Martin** | • Plans in place and continued liaison with services. No major issues identified at this stage but continually being reviewed. |

| | | | |
|---|---|---|---|
| | | | • Supply and demand of fuel being monitored closely, provisions in place should there become shortage of supply<br>• Working closely with our food suppliers- no major issues some issues with failed supply of products but being able to source through low levels of off contract spend.<br>• The Council is also working with schools, its catering division and other partners to ensure that vulnerable children and their families continue to receive the necessary support, which includes access to food/free school meals. Latest data reveals 7090 grab bags and 2,700 hampers are being delivered weekly (which is the equivalent of 13,500 meals), plus a further 1,000 hot meals. Overall, 21,590 meals are being provided to Free School Meal children each week.<br>• Nationally, the DfE has introduced a supermarket voucher scheme for schools to provide to families entitled to free school meals. |
| 2.3 | Ensure sufficient PPE available to key services across the city and that guidance is followed consistently. | **Cath Roff** | • NHS system moved to "push" system to provide PPE when stocks low, with some evidence of this working, but still shortages reported periodically, eg gowns.<br>• Cath Roff appointed as city-wide lead for PPE:<br>  ○ with additional capacity attached to her to help with stock control, logistics etc<br>  ○ with the DPH role to provide guidance based on the national approach<br>  ○ deployment of LRF emergency supplies against agreed prioritisation framework<br>  ○ extensive brokering of mutual aid across the city<br>  ○ awareness raising with the sector on most recent PPE national guidance and its implications<br>• Extensive work to procure and source PPE for non NHS, including at a city wide level and through emergency provision via the LRFs. |

| | | | |
|---|---|---|---|
| | | | • LEP business support package established for businesses who wish to adapt to manufacturing PPE: website https://www.the-lep.com/ppe/<br>• Due to the concerns over PPE shortages in NHS hospitals, social care and emergency services, the Leeds City Region Enterprise Partnership (LEP) and West Yorkshire Combined Authority (WYCA) are working with partners including the council and LRF to support businesses get the crucial supplies to health and social care workers.<br>• Continues to be raised as a key concern locally and nationally with shortages in a range of settings being reported.<br>• Web based access promoted for local services.<br>• Feeding data returns to ensure LRF drops meet demands required. |
| 2.4 | Establish arrangements for food supply to the vulnerable, working with partners and securing an appropriate facility. | **Polly Cook/Lee Hemsworth** | • Local Welfare Support Scheme and frontline customer service workforce adapted to provide two telephone helplines to arrange emergency food provision and non-food support.<br>• New warehouse facility launched to provide a central location for food storage and distribution, linking fleet vehicles and drivers for food deliveries and collections. This larger premises allows food to be packaged within social distancing guidelines. Calls for food provision from the Covid-19 and LWSS helplines are directed to this warehouse for food distribution across the city.<br>• Four Council Community Hubs and 27 third sector organisations remained open to co-ordinate food provision across the city with the Warehouse, working together with existing foodbanks and partners and using VAL volunteers.<br>• As of the 12 May, 11,000 calls for support have been answered from both helplines and over 10,000 food parcels have been packed and distributed since the service began.<br>• Two supermarket voucher schemes in operation to allow volunteers to carry out shopping for residents that are unable to shop for themselves. |

| | | | |
|---|---|---|---|
| | | | • A process for voluntary organisations is being developed to monitor how vouchers are being spent and an eligibility process is also going to be introduced to tackle potential abuse of the system and to ensure the service is supporting those most in need. |
| **3. Business and economic impact** | | | |
| 3.1 | Ensure effective liaison with business, specifically representative bodies to understand impact on local economy (including business confidence) and provide relevant advice or support where possible, including access to government grants. | **Eve Roodhouse** | • Emergency structures in place with workstreams covering: Intelligence; business support; communications; administration; and recovery.<br>• Intelligence hub provides a weekly intelligence report based on information collated from across the council (e.g. city centre footfall) and through proactive contact with businesses and business representative groups (e.g. Chamber of Commerce). Weekly meetings are held with business representative groups.<br>• Business support working with colleagues across the council to ensure delivery of national Government schemes on business rates relief and small business grants schemes and to support commercial tenants and suppliers where required. Good progress continues in the processing of business grant payments. As at 15 May, £130,805,000 has been paid in 10,598 grants, and Leeds is one of the best performing local authority by amount paid.<br>• Following lobbying to national government for an additional local discretionary grant scheme a 'Local Authority Discretionary Grant Fund was announced by central government on 02/05. Further government guidance for local authorities has very recently been published and the council will develop and establish the necessary processes for effective local implementation, ensuring that there is good analysis and understanding of need to inform the approach.<br>• Leeds City Council launched the Leeds MicroBusiness Support Service to support small businesses, particularly independents and those in the retail sector, through the provision of online resources |

| | | | |
|---|---|---|---|
| | | | and information, and dedicated 121 telephone support sessions with local business advisors: https://mybusinessleeds.info/about/<br>• Also worked with WYCA to pivot existing City Region wide business support schemes delivered by Leeds City Council to respond to COVID 19. This includes Digital Enterprise and Ad.Venture.<br>• With Jobshops closed, Employment and Skills (E&S) has continued delivering employment support programmes with check-ins, online learning, job searches, CVs and matching to vacancies by Employment Advisors.<br>• Promotion of current vacancies continues via the Council's webpages and social media and recorded 78 job outcomes for local residents in April.<br>• New customers, and referrals by DWP, can visit Leeds Employment Hub website for support to re-enter the labour market.<br>• The use of on-line classrooms and learning platforms to deliver the Apprenticeship programme continues as well as a programme to enhance Adult Learning providers capacity to deliver on-line courses<br>• New activities have been posted to StartinLeeds, the carers education platform, to support young people in their next steps in education and employment and Career leads in schools are being updated.<br>• Working with the other West Yorkshire authorities, the Council has launched an online regional survey of the creative sector. The results will help inform the priorities for further support going forwards. The Leader of the Council and officers met with the CEO of Arts Council England to further discuss the needs of the sector.<br>• Communications workstream is ensuring that the Leeds City Council business pages on COVID 19 are regularly updated to include relevant information to encourage businesses to claim business grants: https://www.leeds.gov.uk/coronavirus/business |

| | | | |
|---|---|---|---|
| | | | • The team is also leading on social media campaigns relating to implementation of small business grants and promoting good news stories (e.g. Clipper Logistics has partnered with Leeds United Foundation to support LCC's effort to deliver essential food to vulnerable families in need of extra support.).<br>• Recovery: The Leader and Chief Executive joined organisations across West Yorkshire at the first Economic Recovery Board meeting on 30/04. The Board is chaired by Cllr Susan Hinchcliffe, the Leader of Bradford MDC and Chair of the Combined Authority. There has also been an officer group established to support the work of the Board.<br>• Recovery: Work has commenced to complete an initial review of the Inclusive Growth Strategy in the context of COVID 19. Once this is complete we will engage with a wider range of stakeholders on the review. We will use the Inclusive Growth Delivery Partnership to help shape recovery and move forwards. At this stage consideration is being given as to the likely key areas of focus which are expected to include: access to finance; innovation; skills, recruitment and retention; and, the role of Leeds Inclusive Anchors and the Leeds £.<br>• Recovery: Visit Leeds have developed an initial recovery plan which will be refined as more detail emerges on the lifting of restrictions. Welcome to Yorkshire is leading a series of tourism sector recovery meetings bringing together partners across the region. Visit Leeds is joining these meetings.<br>• Businesses across Leeds City Region directed to the LEP as the first port of call: https://www.the-lep.com/business-support/covid-19-support-for-businesses/<br>• Administration includes supporting all workstreams but also accepting offers of support from key partners anchor institutions (offers such as free car parking and spaces in halls of residents for key workers etc.). |

| 4. Citizens and communities impact | | | |
|---|---|---|---|
| 4.1 | Assess the impact on key services and plans for events (e.g. related to areas below) to understand implications for service delivery and plan/communicate accordingly e.g. Schools, Care homes, Commissioned services, Community Hubs, Leisure centres, Waste services. | **Helen Freeman/ All Chief Officers** | • Business Continuity Plans are being continuously reviewed with the pandemic response continuing for a protracted period. Key issues are gathered and clarified with relevant government department.<br>• With lockdown, focus shifted to work out how to follow national guidance with the aim of maintaining essential services whilst ensuring staff and public safety.<br>• Maintained provision for key workers across schools and nurseries<br>• Maintained access to food for FSM children through parcels, vouchers or the early help hubs, with 21,590 meals provided to Free School Meal children each week.<br>• Hot meal provision maintained within Specialist Inclusive Learning Centres (SILCs), ASC Residential Homes and Recovery Hubs and those Early Years Centres which remain open.<br>• Assessed services against clear framework and maintained communications with key stakeholders and the public about the implications and the alternatives for access (cross reference to 5.2 for approach)<br>• The Council's Housing service is working to support tenants that get into financial difficulty by suspending normal recovery action for 3 months, and give advice and support to claim appropriate benefits to assist tenants with paying rent.<br>• Approaches to range of services has changed, all communicated through the daily update and on the website, and this continues through the recovery phase, for example:<br>o Housing repairs and home visits<br>o Planning<br>o Street cleansing<br>o Refuse collection – no longer collecting garden waste<br>o All museums, leisure centres, attractions closed, with some offering online engagement |

| | | | |
|---|---|---|---|
| | | | ○ Libraries closed<br>○ Retained 4 community hub sites for urgent appointments<br>○ Reduced number of schools and children's centres open to provide access for key worker children<br>○ Children's Homes staying open<br>○ Care homes open, but 24 outbreaks that are being managed |
| 4.2 | Monitor community tensions and providing community reassurance through regular channels e.g. faith and community leaders, responding appropriately when required. | **Shaid Mahmood** | • Partnership arrangements in place and being used to promote messages of reassurance and to be aware and respond to any issues which may arise.<br>• Particularly focused with faith sector on death management issues<br>• Work has been progressed with Muslim faith and community leaders to develop a suite of public health information to support Muslims during the Ramadan period as well as providing a guidance leaflet on constraints during what is a communal month.<br>• Chief Officer Communities has met with representatives of the Leeds Faith Forum and a further meeting with a wider group of faith leaders is planned.<br>• A community tensions report has been developed by Safer Leeds and is being effectively used to deploy resources to counter tensions.<br>• Work to understand COVID-19 related inequalities in the city has been initiated and a report will be developed.<br>• Support provided to migrants, asylum seekers and refugees and those with no recourse to public funds. |
| 4.3 | Ensure effective liaison with the third sector (VCFS organisations) to understand impact and provide advice and support to ensure a coordinated and safe approach to the use of community capacity. | **Shaid Mahmood** | • Guidance shared with third sector representatives.<br>• Volunteering scheme with Voluntary Action Leeds has been launched allowing people to provide community care and support in a co-ordinated way that keeps everyone safe. Once signed-up volunteers will receive training and then be matched with |

| | | | |
|---|---|---|---|
| | | | opportunities locally to help. Over 8,000 volunteers identified, of which over 5200 have been inducted with VAL.<br>• Structured approach – tier 1 are DBS checked; tier 2 are for other services where DBS not required; with tier 3 focussed on community and citizen led activity, using an Asset Based Community Development Framework and approach, promoting and nurturing a range of activity across the city, including friendliness, neighbourliness, role of civil society, and making connections – 'Socially Connected whilst Physically Distant'. Crucially this reduces demand on both formal volunteering and services as communities and neighbours come together to take action to support each other.<br>• LCC helpline has been launched to enable members of the community to make contact and be matched with a local volunteer.<br>• Letter provided and name badges sorted.<br>• Weekly Third Sector meetings are being held and a Third Sector Resilience survey is underway.<br>• A review of has been initiated to examine the sustainability of the current volunteering arrangements for the medium term and to consider improvements.<br>• "Are U Ok?" Service introduced to help support individuals that have requested a check in and chat/welfare calls.<br>• Considerable work is underway to understand the requirements of PPE for volunteers that need to cross the threshold of someone's home and if required, to equip those volunteers to do so.<br>• To date, adequate supplies of PPE to comply with national guidance has been maintained throughout with mutual aid between organisations.<br>• 33 ward-level Facebook pages have been created and are being actively used to post updates and information.<br>• 33 Volunteer Coordinator Hubs have been established for each ward across the city. 5629 referrals were made to the hubs between 24th March and 28th April, following a significant increase in calls to the |

| | | | |
|---|---|---|---|
| | | | helpline since the leaflet drop took place. The majority of the requests received are for help with food and essential shopping, prescription collection, dog walking and befriending and reassurance calls.<br>• A team of Helpline Liaison Support staff from across the Communities & Environment directorate is being established to ensure the referrals are accurately and effectively allocated to the Volunteer Coordinator Hubs.<br>• The Executive Member for Communities has written to the third sector to encourage them to make contact with their council contract manager to see how the council might offer help and support in light of anticipated funding and cash flow issues for the sector in the medium-term.<br>• Voluntary Action Leeds has initiated a survey of the sector with its findings. The council is also exploring the detail of a recent government announcement to top up the local business grant funds scheme aimed at small business with ongoing fixed property-related costs which includes small charity properties that would meet the criteria for small business rates relief. |
| 4.4 | Recognising the community understanding role of Councillors, ensure appropriate information is provided to elected members to enable them to support the community in their wards. | **Shaid Mahmood** | • Daily communication issued to all councillors with relevant guidance and information related to local impact including cases in Leeds, LCC service disruption, food provisions, shielding and volunteering updates, economic impact report. Signposting to national guidance and advice remains ongoing.<br>• 33 ward-level Facebook pages have been established to encourage communication and share important messages.<br>• Ward level organisations in place and supported by VAL and some LCC capacity to ensure effective during this crisis.<br>• The Community Committee Chairs Forum has re-established Skype-based meetings and some community committees have met on a consultative basis in April. Wellbeing and Youth Activity Fund |

| | | | |
|---|---|---|---|
| | | | positions for each committee have been reviewed and spend patterns on a ring fenced £10k of wellbeing fund have been shared. |
| 4.5 | Ensure that there is access to a coronavirus helpline to provide support, help the vulnerable meet needs and signpost to other services where appropriate. | **Lee Hemsworth** | • Helpline established receiving on average between 300-500 calls per day from citizens requiring a range of support from food, medicines, loneliness and poverty. Support being provided to call-handlers from range of multi-agency colleagues within Health and Social Care.<br>• Leaflet drop to 330,000 households to highlight support and help available. Now translated into 12 community languages online.<br>• Staff on the Helpline triage the support customers needed and task out to Adult Social Care, the food distribution warehouse or the 33 volunteer hubs.<br>• Staffing implications have meant other, non-priority lines within the Contact Centre have closed, but that has been communicated.<br>• Calls for food provision from the Covid-19 and Local Welfare Support Scheme (LWSS) helplines are directed to either the emergency food warehouse or the lead Voluntary Organisations in each ward for food distribution across the city. From 16 March to 1st May a total of 12,864 food parcels have been packed and provided.<br>• A process to allow citizens to pay for their food shopping was introduced on the 30th April 2020<br>• A team of Helpline Liaison Support staff from across the Communities & Environment directorate is being established to ensure the referrals are accurately and effectively allocated to the Volunteer Coordinator Hubs. |
| 4.6 | Ensure that support is provided to the shielded cohort as outlined in the guidance, including distribution of food provision | **Tony Cooke/Polly Cook/Lee Hemsworth** | • The NHS has identified a number of medical conditions that would most likely result in severe illness requiring admission to hospital as a result of Coronavirus. Because of this high risk of complications, it is proposed that individuals with these conditions take significant measures to shield themselves from contracting the virus through strict social isolation for a period of 12 weeks. |

| | | | |
|---|---|---|---|
| | | | • Based on original estimates of numbers, Leeds was estimated to have had a shielding cohort of 22,532 people. In subsequent weeks, secondary care and primary care have done an extensive search of patient records, to identify patients whose combination of conditions would also raise their risk from "moderately vulnerable" to "extremely vulnerable". The new estimated figure as of 11th May for people in Leeds advised to shield, is now 45,713, over twice the original estimate. Other areas of the country have also seen significant increases in numbers advised to shield. Work is underway currently to better understand the scale of the increase.<br>• To date 16,099 people (67% of the original cohort, or 35% or the new expanded cohort) have confirmed they have received the letter to shield by registering with the national shielding service. 4,628 people have said that they would need help with accessing food and basic supplies. 1,221 of these (26%) regularly receive a Basics Box delivered by national government, a further 486 have received one Basics Box delivery and 491 have asked to be removed from these deliveries permanently. The rest are offered support by our local volunteer support, food banks or informally through neighbours. Since the week commencing 27 April, the council has also been sent details of 1,203 people who say they may need some assistance in meeting their "basic care needs". Significant piece of work is now underway to cross reference this with local requests for assistance that are already being processed, before making contact.<br>• All families with children who are advised to shield are being sent a letter containing relevant information and signposting to local support specifically for children and families.<br>• Targeting efforts to ensure that information about shielding is shared in minority ethnic communities across the city, working with third sector organisations, faith communities and sharing this data with primary care, particularly in areas that have higher numbers of BAME residents. |

| | | | |
|---|---|---|---|
| | | | • The Council is working with supermarkets to offer priority services to this cohort as well as promoting the local support offer.<br>• Following the release of government guidance around shielding, processes are being established to ensure emergency food provisions, phone support and signposting is provided to those in need (lead by Chief Officer Health Partnerships).<br>• Each person on the list who has expressed a need for help and support is contacted directly either via text, email or phone call and the helpline number is provided for them to call should they need help.<br>• A multi-agency approach has been taken to ensure that people will have access to the support they need through this period.<br>• A dedicated helpline number has been established in Leeds to help coordinate matching people with the support they need.<br>• The local Shielding Team periodically sends out updates to all people who have confirmed they are shielding, with practical information about where to get help with accessing food, welfare support or social support.<br>• Coordination of work on financial inclusion.<br>• Categorisation of type of support and clarification of pathway being worked through in advance of more formal approach to launching and promoting this additional mobilisation of community capacity both formal and informal.<br>• The local "check in and chat" service, called 'Are U OK? has been introduced and information on this will be been sent directly to people who are shielding. |
| 4.7 | Ensure that we take an intelligence led approach to deal with emerging or anticipated issues as a result of the impact of coronavirus eg domestic violence, rough sleepers, release of prisoners, managed approach, NRPF | **Paul Money** | • Daily Threat report evolved to provide more focussed intelligence picture to aid the deployment of resources in an intelligence led way. e.g. tracking COVID-19 OCG activity including frauds and scams being targeted on vulnerable people.<br>• To address issues associated with DV&A we have now set up COVID-19 Officer Group to review our capacity and capability and stress |

| | | | |
|---|---|---|---|
| | | | test arrangements to ensure we are able to support victims and families at a time of heightened demand - with indications that demand will increase further over coming weeks and months as social distancing guidance is relaxed.<br>• Safer Leeds is maintaining close liaison/ coordination with all partners including third sector support charities/organisations to ensure we have resilience in our partnership capacity and no interruption of services. This includes monitoring the availability of specialist accommodation support for those at risk of DV&A<br>• Rough sleeper accommodation has been further enhanced to include COVID-19 Care, COVID-19 Protect and general population offers. Rough sleepers are also being offered PPE as are colleagues working with this high risk group. 215 people are currently being supported in emergency accommodation – approximately 25% of whom have been physically seen rough sleeping in the city at least once in the last 12 months by street support services.<br>• New arrangement for the support of street based sex workers are now being further embedded. Support to sex workers is being delivered in a different way and most women on the cohort are now not believed to be street sex working. Those that continue with such activity are being engaged dynamically and supported to refrain by resources forming part of the Managed Approach partnership.<br>• Services including accommodation providers are supporting individuals who are assessed as being without recourse to public funds on the basis of the indiscriminate nature of COVID-19.<br>• Working group set up to address issues arising from the national Prisoner Early Release Scheme. No significant threat in Leeds due to the low volume of prisoners being considered for early release. The original issue around the need to alleviate pressure in the secure estate (5000 prisoners) has now significantly dissipated (at least for |

| | | | |
|---|---|---|---|
| | | | the time being) mainly due to the major reduction in the number of people being sentenced by the courts. Local arrangements may come under pressure due to the volume of people who are now being made subject of bail and curfews and remaining in the community as opposed to being required to attend Trials but we have partnership arrangements in place to keep this under review.<br>• All relevant community safety services are currently engaged in 'return to normality' planning in anticipation of further Government/Health announcements linked to the pandemic with a focus on the impact on people and services. |
| 4.8 | Ensure that vulnerable children and young people are safeguarded as far as is possible during this pandemic given that services cannot be provided in the normal way. | **Sal Tariq** | • Social work service maintained but requiring social distancing<br>• Social Work, schools, early help, targeted/specialist services and key partners working together at a cluster level to identify vulnerable children/young people to ensure a line of sight on them and robust support plans.<br>• Multi agency Bronze groups taking place each week in the East, South, West of the city to provide a strategic response to emerging issues at a cluster level.<br>• Children and Families staff contacting the families of shielded children to offer support.<br>• On line and practical resources developed and shared with vulnerable children and their families.<br>• Early Help hubs ensuring that vulnerable children and their families are provided with food and other essential provisions as well as on-going Early Help.<br>• Domestic Violence, Substance Misuse and Mental Health specialists based in the Early Help Hubs providing advice and support to professionals and families.<br>• Support being provided to families where Parental Conflict is an issue to prevent escalation |

| | | | |
|---|---|---|---|
| | | | • Allocations meetings increased to 2 meetings a week to ensure timely provision of targeted/specialist support to vulnerable children and their families.<br>• Children and Families DV officer group established to look at support available to families during the current pandemic and feeding into Safer Leeds Covid-19 DV officer group.<br>• 13 childcare hub sites remain open with increasing numbers of children attending.<br>• Children and Families staff working with key with partners to investigate whether appropriate numbers of vulnerable children are attending school<br>• Identified children/young people who are eligible for a free laptop through the government scheme and supporting the rollout of this.<br>• which can in turn impact on children in the household.<br>• Free school meal provision is continuing. |
| 4.9 | Supporting schools to provide education for key workers and "re-open" in line with national guidance. | **Sal Tariq** | • Very regular bulletins with schools and staff supporting schools with a range of practical issues as well as safeguarding (as above)<br>• Encouraging schools to collaborate to provide care for key worker children<br>• Engaging with head teachers/principals now weekly with the Leader and Executive members<br>• Bronze arrangements now in place to help plan for nurseries, primary and secondary, with connections to other groups where needed eg shielding, transport etc.<br>• Developing a framework to help interpret guidance and providing a steer about implementation. |
| 4.10 | Establish a hardship fund in line with government guidance and to meet local need | **Victoria Bradshaw/Lee Hemsworth** | • Processes are in place, including a new on-line form, for citizens to seek a delay in paying their monthly Council Tax payments. Residents are entitled to request up to a 3 month council tax deferments for those financially affected by the |

| | | | |
|---|---|---|---|
| | | | pandemic and reschedule payments over the remaining 9 months of the financial year.<br>• The Council is working with residents to ensure customers understand that they should only seek deferment if they cannot afford repayments, and is encouraging customers who can afford to pay to continue as normal. Latest data has shown that 2,500 -3,000 Leeds residents have applied for the 3 month deferment to repay later in the year.<br>• Further work is ongoing to develop the hardship scheme, which in the main will bring support to those on Local Council Tax Support or those who may come into this cohort as a result of the current situation. Options are being developed following liaison with other councils and specialist bodies about the best way to implement the scheme which will be implemented by the end of May as the required software changes won't be made until this time. |
| **5. Organisational impact** | | | |
| 5.1 | Ensure joined-up cross-departmental approach to Coronavirus (COVID-19) response within the council, within the context of the emergency management arrangements. | **Neil Evans** | • This Response and Recovery Plan is being used to ensure coherence and consistency as well as compliance with national guidance. The plan is reviewed regularly and updated accordingly.<br>• Multi-agency command and control arrangements in place and within the organisation. More frequent engagement with chief officers so everyone clear about role and expectations and a consistent approach is taken |
| 5.2 | Ongoing assessment of business continuity plans for the council's critical and non-critical services to understand the implications of the relevant scenarios and options for maintaining services. | **Mariana Pexton/Andy Dodman/Helen Freeman/all chief officers** | • In line with expectations of Corporate Governance and Audit Committee, the framework was utilised for Business Continuity Planning<br>• All services have completed an essential service prioritisation exercise to aid decisions and actions on work force redeployment and PPE provision (for example). This prioritisation work will be refreshed at regular intervals.<br>• Recruitment is continuing into care roles and children's homes with fast track training in place. |

| | | | |
|---|---|---|---|
| | | | • Extensive work to ensure redeployment to key areas, with use of a skills questionnaire and a redeployment team, to complement lots of informal arrangements where staff are being used across services to help maintain essential services<br>• The delivery of many front line services has been reduced in response to national guidance and messages. Where services are continuing, appropriate measures have been taken to ensure adherence to national guidelines.<br>• Managing expectations of the level of delivery as increasing proportion of the council's workforce is affected (e.g. because of self-isolation or illness) is a key issue of consideration.<br>• Leading on council-wide discussions regarding the resumption of services and working towards a plan about which services can resume and when. |
| 5.3 | Identify council service budgets which may require additional financial investment or underwriting as a result of reduced income or increased expenditure. Consider requesting additional funding from government and the most effective use of funding from central government. | **Victoria Bradshaw** | • Systems have been established to capture the impact/potential issues so that these can be reflected in evidence for additional funding requests e.g. business grants, hardship schemes, social care funding etc. (Cross reference to 3.1 on business grants)<br>• A full account of additional costs will be maintained and reported regularly so additional budget pressures can be identified early.<br>• Extensive liaison with colleagues in other authorities and sector bodies to influence government to support councils<br>• Submissions being made to MHCLG when required<br>• Report to Exec Board planned for May to highlight issues and options. |
| 5.4 | Ensure regular engagement with council contractors and suppliers to identify any potential impact or risks to contractor performance. | **Victoria Bradshaw/ Commissioners** | • Liaison across services taking place with contractors and providers so that issues can be captured and responded to.<br>• National advice and support is communicated to suppliers to ensure that a consistent message is circulated. |

| | | | |
|---|---|---|---|
| 5.5 | Track impact on council workforce affected by Coronavirus (COVID-19), including a period of staff absence, staff welfare, workplace conditions, intervening and issuing regular up to date guidance as required, so that managers can support individual members of staff. | **Andy Dodman** | • Liaison with trade union representatives and extensive advice to workforce from a health and safety and general employment perspective.<br>• Work with trade union colleagues continues, with any vulnerable staff who are at work are doing so willingly and have Occupational Health advice. Extensive guidance to managers is being issued weekly.<br>• A central reallocation pool has been created. Managers are invited to log where there is supply and demand in their service. Staff will be supported to complete skills surveys to inform redeployment decisions, and all this will be carried out in-line with our values and through engagement with line managers.<br>• There has been a focus on supporting staff in vulnerable groups who are working in frontline critical services by matching surplus resource with these roles.<br>• Staff volunteers will be identified through the essential services redeployment pool and for staff who are able to work but are not needed to support an essential service, they will be matched where possible to the VAL volunteering roles.<br>• New categories for reporting established and a flexible resourcing plan developed to help respond to business continuity issues.<br>• Strong links developed with anchor organisations and other city employers to support wider resource deployment as and when necessary.<br>• Council PPE stock is being efficiently distributed to those services where it is required. |
| 5.6 | Work across the City as a whole to lead and coordinate the delivery of the necessary Digital and Information solutions to underpin the whole City operation through the ONE City approach to Digital and Information. Maintain | **Dylan Roberts** | • Enabled 9000+ LCC staff to stay safe and work from home at the same time, regularly with more than 8000 users including the contact centre |

| | | | |
|---|---|---|---|
| | and emphasise the ONE city approach to continue beyond the crisis.<br>• Prioritise use of available resources to maintaining the availability of critical communication and IT systems<br>• To make infrastructure changes and arrangements to enable remote working for large numbers of staff<br>• Protect the Council and partners from opportunistic cyber attack | | • Rolling out new solutions enabling our GPs and other primary care staff to work from home, provide online consultations and share resources across practices to support the demand<br>• Combining the intelligence from multiple sources to identify hot spots and those most at risk in order to inform a targeted response<br>• Providing the collaboration technology and tools to enable the diverse third sector of Leeds to coordinate efforts and enable thousands of new "checked" volunteers<br>• Rapidly developing new web based and social media based solutions to enable new services to give much needed help fast eg business grants<br>• Supporting partners without the necessary skills to upgrade their systems due to massive increase in demand. Enabled VAL to run a payroll for 170+ 3rd sector organisations in the City with a massive increase in "employees" and getting key workers paid.<br>• Our 100% Digital Literacy Leeds and Smart Leeds teams are enabling our third sector to get a significant number of our most isolated people online and connected to family, friends and health professionals, rolling out critical MyCOP App to those at high risk.<br>• An example of the City Digital approach enabling staff and the public, in this case the GP and the patient see tweet https://twitter.com/rachalate/status/1247582714297016330<br>• Nominated as one of Matt Hancock's COVID19 HeathTech Heroes<br>• Working with partners, the council's IT team has rapidly developed an application to support the online booking system, helping to manage the demand of Household Waste and Recycling Centres, following the recent announcement to open specific sites. |
| 5.7 | Ensuring accurate and timely intelligence to support effective response and recovery | **Polly Cook/Simon Foy** | • Broader intelligence to support and link to existing arrangements in H&SC system. |

| | | | |
|---|---|---|---|
| | planning through a cross-council/wider system intelligence group to:<br><br>• Share key analysis and headlines;<br>• Identify gaps in data and analysis:<br>• Share capacity and resources:<br>• Provide common/consistent feedback on intelligence issues. | | • Intelligence group established backed up by weekly call to identify issues, fill gaps by joint working and highlight key areas of concern.<br>• Data Mill North and Leeds Observatory promoted as platforms to share data and analysis and to facilitate collaboration.<br>• Range of individual thematic and policy updates shared across the group and a weekly headline summary report established.<br>• Joint working underway on key areas such as COVID19 impact, tracking vulnerable and shielded cohorts, socio-economic insights/impacts. |
| 5.8 | Assess the impact on events planning and management to understand implications | **Mariana Pexton/Cluny McPherson** | • Strategic Safety Advisory Group and Major Events Project Board will be used as the forum for this, within the context of national guidance.<br>• A large number of our venues and facilities (including Leeds Town Hall, Carriageworks, and Pudsey Civic centre) have now closed to the public and will remain so throughout March and April.<br>• A number of events due to take place have now been postponed or cancelled. These include the Vaisakhi Parade, 2020 Tour de Yorkshire and Asda Tour de Yorkshire Women's Race, the AJ Bell World Triathlon Leeds, Leeds West Indian Carnival 2020 and the Leeds Young Film festival, Pride and Leeds Fesitval.<br>• Calendar of events in the city being continually reviewed and complex issues worked through.<br>• Consideration to be given to an event to thank the city's key workers and pay tribute to those who lose their life |
| 5.9 | Ensure other emergency plans are refreshed and invoked as appropriate for the circumstances or refreshed recognising the current context/situation e.g. unexpected deaths, rest centre plan etc. | **Mariana Pexton** | • Unexpected deaths plan has been refreshed<br>• Flexible resourcing plan has been invoked<br>• Work in hand and issues will be raised and resolved as the situation develops. |
| 5.10 | Ensure that governance issues are considered and adapted for a range of scenarios for | **Andy Hodson** | • All meetings now facilitated through Skype |

| | | | |
|---|---|---|---|
| | continuing member and officer business during the outbreak whilst also ensuring good governance. | | • Sub delegation schemes have been adapted with an emergency clause to enable alternative officers to make decisions if required.<br>• IT for members has been adapted to ensure they can conduct council business remotely and appropriate kit and training has been offered.<br>• All upcoming council meetings being considered, along with surgeries, in order to give advice. |
| 5.11 | Ensure that our arrangements for death management are handled appropriately and sensitively in line with guidance and excess deaths plan and policy. | **James Rogers** | • Excess deaths plan refreshed and associated policy prepared and agreed<br>• Changes made to burial and cremation arrangements in line with excess deaths plan and policy to keep people safe and protect lives<br>• Proactive liaison with faith sector/leaders, funeral directors and other key stakeholders<br>• Councillor updates include death figures and<br>• Agreed development of emergency mortuary provision in line with excess deaths plan. Site delivered and operationally ready.<br>• Link with other authorities on excess death plans to ensure that there is capacity and arrangements to deal with anticipated deaths in line with the Reasonable Worst Case Scenarios (RWCS) or other advice given by key national departments (eg Worst Winter Deaths) |
| **6. Media and communications** | | | |
| 6.1 | Capture the scale of enquiries, activity and impact through communications channels. Respond to media enquiries, referring to lead body/organisation where appropriate. | **Donna Cox/Danni Clayton** | • Brandwatch social media monitoring queries on coronavirus and related topics in place. Informs reporting and proactive planning.<br>• Volume of media requests high: prioritising around those that are coronavirus-related or major reputational threats for the city<br>• Proactive media work continuing, informed by strategic direction and monitoring and prioritised around coronavirus handling<br>• Three times weekly media summary incorporating enquiries, proactive releases and social media planning/monitoring produced, helping to feed updates for BCLT, members and MPs and regular partner briefings. |

| | | | |
|---|---|---|---|
| | | | • Silver communications leads group established for key partners on Gold Strategic Command that links communications between partners and channels Silver Health Group information (via its health communications leads).<br>• Weekly press briefings taking place remotely since April. |
| 6.2 | Effective liaison and engagement with Public Health to promote communication and information sharing with key services (such as, Schools, Waste services, Higher/further education institutions, Health sector, Social care, Third sector, Faith organisations/leaders etc), the public and workforce. | **Sara Hyman** | • Range of communications issued and specifically advising reference to continually updated national guidance e.g. for schools etc seeking to ensure coherence and consistency on guidance from government.<br>• Communications work streams established for all key Silver groups – Health, Communities, Business and Infrastructure and Organisational Impact<br>• Sub-groups in place to coordinate Marketing and Campaigns, Digital and Social, Press media and PR and Internal comms coordinating and promoting communication and information sharing with key services and audiences<br>• Digital forecast in place three times weekly for social media and digital channel owners to ensure coordination of messages across council channels. |
| 6.3 | Regularly update key stakeholders across the council and city, in particular, elected members and MPs, CLT, BCLT, COVID-19 (Coronavirus) response working group, schools, updates to Executive Board, stakeholders/partners, workforce etc. | **Mariana Pexton** | • Regular councillor and MP emails being sent, including guidance and signposting to further information,<br>• Regular all staff emails, and FAQs issued (refreshed when new national guidance is produced).<br>• A staff Facebook page has been established to ensure a greater reach out to Leeds City Council staff.<br>• Two dedicated webpages created on leeds.gov to host information for residents and communities; and businesses<br>• GovDelivery Coronavirus weekly newsletter sent to circa 116k<br>• Messages to schools being issued, in line with DfE guidance, from the DCS<br>• Leader and Chief Executive monthly communications used to reach broader stakeholders regularly. |

| | | | |
|---|---|---|---|
| | | | • Weekly calls with MPs. Regular calls with headteachers, businesses, third sector partners and other partners.<br>• Communications have been increased to amplify national messages and changes to services via the website, virtual newsroom and Leeds Alert. |

# Coronavirus - Gold Covid Strategic Coordination Group

**Weekly Report - 12th May 2020**

Leeds CITY COUNCIL

## Headlines

### Health and Social Care

Cases and Hospital Occupancy have slowed, however, significant concerns remain, regarding the most vulnerable (care homes cases rose steadily throughout April); PPE supplies; and, the speed at which testing can be accelerated.

### Citizens & Community

Generally widespread compliance with restrictions continues though there was a slight peak on the Saturday of the BH weekend. Concerns remain around domestic violence during the lockdown. The majority of calls to the LCC helplines relate to food and essential shopping, centred on the south and east of the city centre.

### Economy and Business

Cash flow and access to finance remain the key issues. However, reflecting the speculation regarding easing of lockdown, focus continues to shift to safe re-opening and managing social distancing, firms believe staff confidence in coming out of lockdown will be crucial, with some identifying questions around employers' liability in managing a safe return to some form of normality.

### Infrastructure and Supplies

Shortages of PPE continue to be a challenge. Again perhaps reflecting the speculation regarding easing of lockdown over the last week, there are early signs of increased footfall and traffic, particularly at rush hour and over the weekend.



**1,635**
**Total Covid-19**
Reported in Hospitals

**36**
**New Cases**
Reported in latest update

**58.6%**
**Critical Care Beds**
Reported as occupied in LTHT Hospitals

**11**
**Patients**
In receipt of mechanical ventilation

**205**
**People**
In emergency Accommodation


**1544**
**Covid related**
Incidents reported to West Yorkshire Police

**446**
**Domestic Incidents**
reported to WY Police in last week

**359**
**Covid warnings**
Issued by WY Police in the last week


**472**
**Grants paid**
to local businesses this week


**£5.6m**
**In grants paid**
paid to local businesses this week

**6.9%**
**Footfall in Leeds**
Based on figures for the same week last year

**12,500**
**Website Visits**
To Covid guidance pages on LCC website

# Coronavirus - Health and Social Care Impact

## Weekly Report - 12th May 2020

**1635 Total Covid19 Cases Reported in Leeds**

**36 New Cases Reported in latest update**

**277 Hospital Covid19 deaths**

**471 Registered Covid19 Deaths**

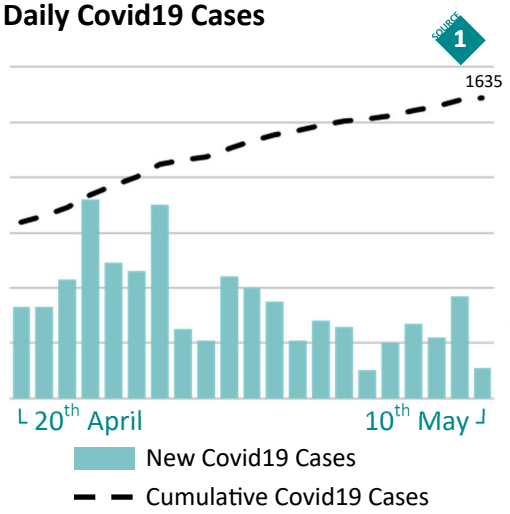
**173 Registered Covid19 Deaths in care homes**



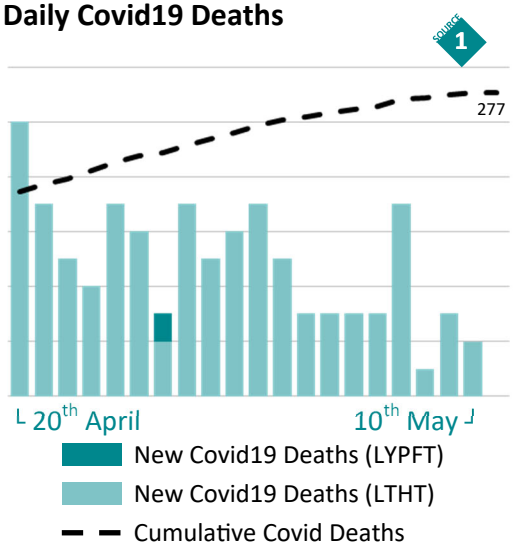
Cases and Deaths in Leeds

Daily Covid19 cases are revised each day by Public Health England and as such historic figures may be updated retrospectively. Consequently, the latest daily figure provided below is unlikely to accurate represent the true number of cases confirmed for that day.

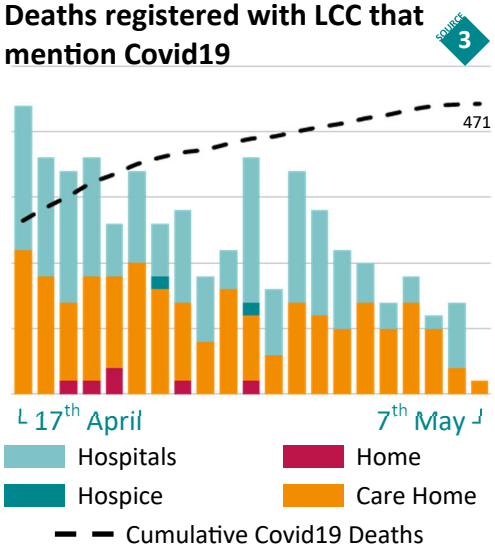
### Daily Covid19 Cases



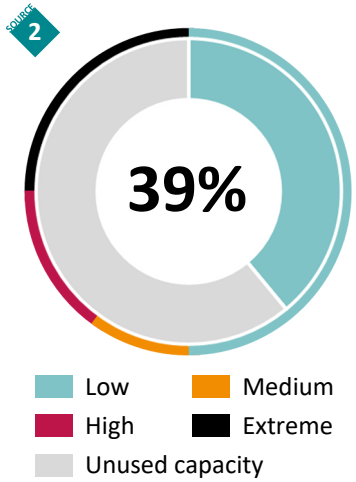

### Daily Covid19 Deaths




### Deaths registered with LCC that mention Covid19




### Mortuary Capacity Data



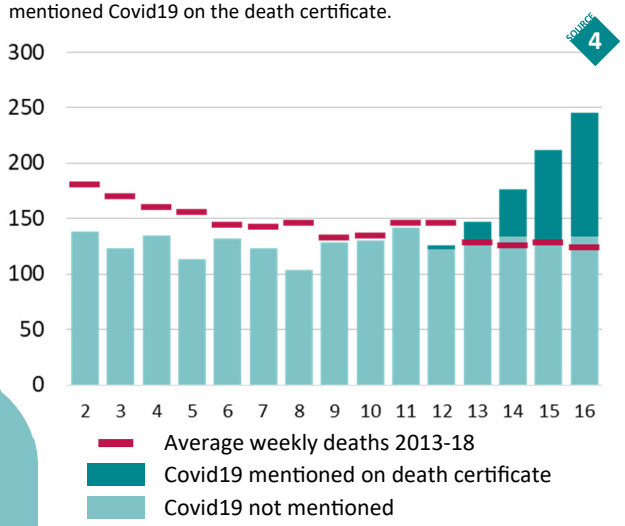

Combined data for LTHT and MYHT.
Does not include Waterside facility.
*Not updated 12/05 due to VE Day bank holiday

### All Deaths in 2020

The chart below shows the number of deaths by week in 2020. Deaths where Covid19 is mentioned are highlighted in dark green. This chart also gives the average deaths in the same week for the years 2014-2018 (red bar).

The chart shows between weeks 2 and 12 the number of deaths in 2020 was lower than average, and for weeks 13 to 16 the number of deaths were higher than average.

In week 16, Leeds recorded 122 excess deaths, of which, 111 mentioned Covid19 on the death certificate.




As of Sunday 10th May 2020 17:00, the number of confirmed cases within Leeds equalled 1,635. A further 36 confirmed cases were added to the total yesterday. Deaths in Leeds

As of 10th May 2020, the total number of reported deaths of people who tested positive with COVID-19 in Leeds hospitals is 277 (275 reported at LTHT; 2 reported at LYPFT). There was 1 new death reported yesterday. Interpretation of these figures should take into account the fact that the number of deaths, particularly for recent prior days, are likely to be updated in future releases. Cases are only included in the data when the positive COVID-19 test result is received or death certificate confirmed with COVID - 19 mentioned. This results in a lag between a given date of death and exhaustive daily death figures for that day.

As of 7th May 2020, a total of 471 COVID-19 related deaths had been registered by Leeds Register Office. Of these deaths, 269 (57.1%) were in hospital, 173 (36.7%) were in care homes, 20 (4.2%) in their own home and 9 (1.9%) in a hospice. 62.7% of deaths which occurred during the most recent 7-day period were in care homes. Deaths are charted by date of death, further deaths may be added to recent dates as death registrations are updated. <3>

Due to the average time taken to registering a death (3-4 days), data from the Leeds Registrars Office should be interpreted carefully as they're subject to change considerably more so than LTHT figures.

Sources:

1) Leeds Teaching Hospital Trust - 11/05/20
2) Leeds Resilience & Emergencies - 30/04/20
3) Leeds Registrars Office - 07/05/20
4) PHINE - Using ONS Data -2014 - 2019

# Coronavirus - Health and Social Care Impact

## Weekly Report - 12th May 2020

**1635 Total** Covid19 Cases Reported in Leeds

**36 New Cases** Reported in latest update

**127 Cases** Reported active in Care Homes

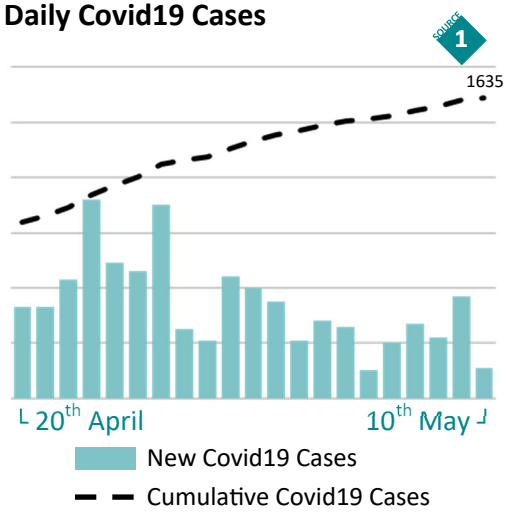
**52.1% Beds** Occupied in LTHT

**58.6%** Critical Care beds occupied in LTHT

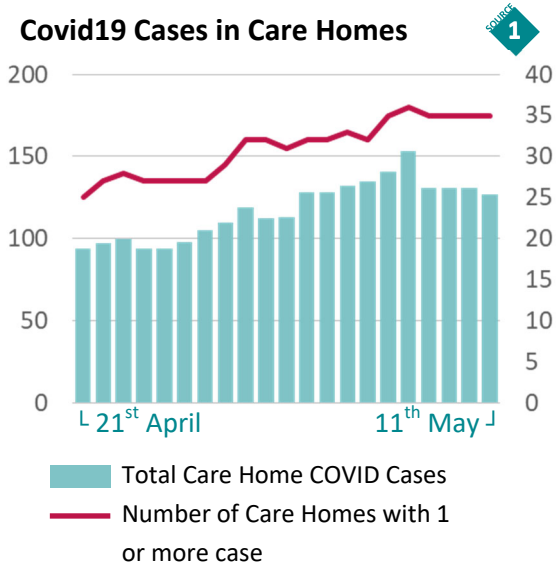
**11 Patients** Receiving mechanical ventilation



### Daily Covid19 Cases




### Covid19 Cases in Care Homes




Sources:

1) Leeds Teaching Hospital Trust - 11/05/20

As of Sunday 10th May 2020 17:00, the number of confirmed cases within Leeds equalled 1,635. A further 36 confirmed cases were added to the total yesterday. Deaths in Leeds

**Bed Occupancy**

At 08:00 on Monday 11th May 2020, 158 beds were occupied at LTHT by confirmed COVID-19 patients; an increase in 7 patients compared to the previous day (+4.6%; similar increases observed in acute settings for WY&H and National). A further 73 beds were occupied by suspected COVID-19 patients (a reduction by 57% compared to the previous day).

Although the reduction in beds occupied by confirmed COVID-19 patients is in contrast to the recent reduction in bed occupancy, it is currently unknown if this is a one-off occurrence, if there's a link between the increase in beds occupied by confirmed patients and reduction in beds occupied by suspected patients, or for some other reason. Changes in bed occupancy over the coming days will help with further understanding.

52.1% of general and acute beds at Leeds Teaching Hospitals NHS Trust were reported to be occupied and 58.6% of critical care beds were also occupied, 17 of these beds being occupied by confirmed COVID-19 patients.

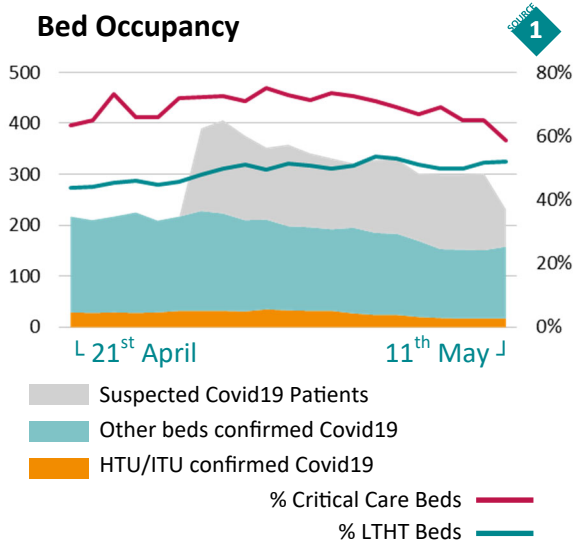
11 confirmed COVID-19 patients at LTHT were occupying mechanical ventilation beds and on an oxygen supply. 6 confirmed COVID-19 patients were occupying non-invasive ventilation beds and in receipt of oxygen, and a further 130 confirmed COVID-19 patients were in receipt of oxygen.

21 beds were occupied at Leeds and York Partnership NHS Foundation Trust by confirmed COVID-19 patients (an increase from 8 compared to yesterday).

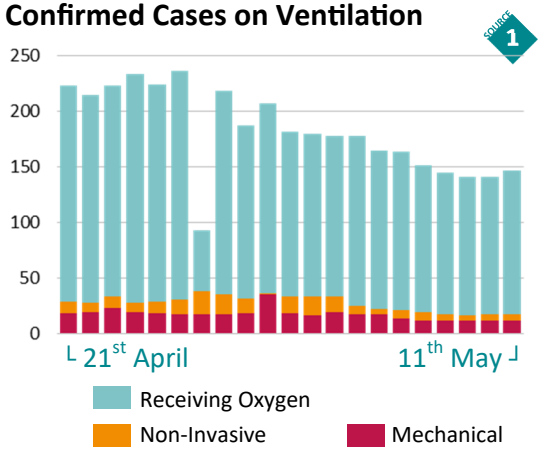
**Covid Discharges at LTHT**

On Sunday 10th May 2020, there were 3 discharges from Leeds Teaching Hospitals NHS Trust, with all patients being discharged to their usual place of residence. The total number of patients discharged to date equates to 453 patients (83.2% to their usual place of residence).

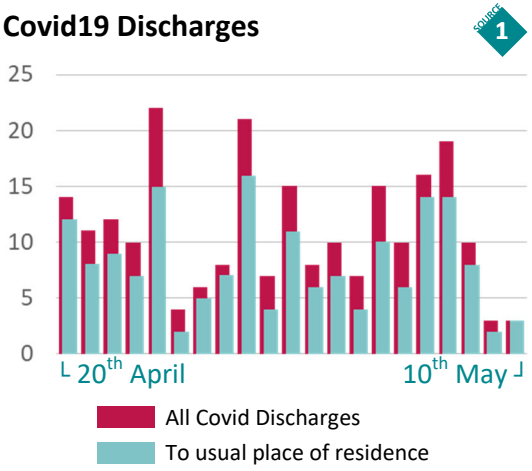
### Bed Occupancy




### Confirmed Cases on Ventilation




### Covid19 Discharges



# Coronavirus - Citizens and Community

## Weekly Report - 12th May 2020

**1544 Covid19 related Incidents last week**

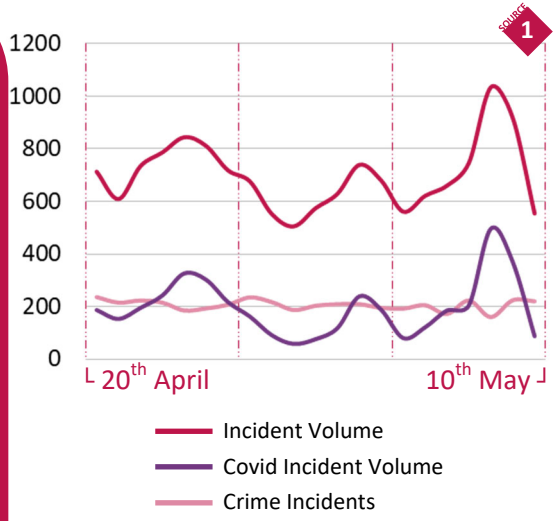
**446 Domestic incidents reported last week**

**359 Covid19 related warnings issued last week**

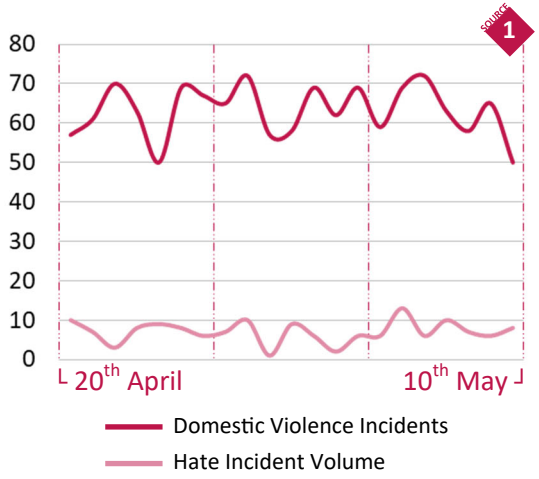
**205 People in emergency accommodation**



### Incidents, Crimes & Covid Incidents




### Domestic Violence & Hate Incidents




Sources:

1) Safer Leeds - 10/5/20
2) Leeds Children's Services - 5/5/20
3) Leeds Adults Services 09/05/20

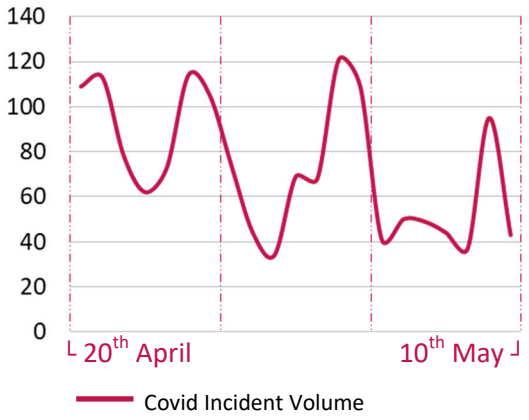
### Incidents and Crimes Overview

Generally widespread compliance with restrictions continues; majority of non-compliance reports concern single individuals outside unnecessarily or making non-essential journeys, or couples/ small groups congregating. The concerns around increasing domestic incidents and violence during the current social lock-down period.

| Weekly totals | Volume | Change |
|---|---|---|
| Crime | 1396 | -59 ▼ |
| Incident | 5095 | 741 ▲ |
| Covid Incident | 1544 | 613 ▲ |
| Covid Warnings | 359 | -160 ▼ |
| Domestic Incidents | 446 | -12 ▼ |
| Hate Incident | 48 | 0 = |

### Covid19 related warnings issued

Source 1




### Emergency Accommodation

Source 3

As of Thursday 7 May 2020 there were 205 people in emergency accommodation. An decrease of 10 people compared with the previous week.

### Shielded Persons

Source 3

There are over 22500 residents in Leeds considered to 'clinically vunerable' requiring shielded support, to date over 18000 have been contacted and over 15099 have registered with Leeds City Council for support. Many of those identified in the shielded cohort will not require targeted support.

| Living Situation | Est. | Registered |
|---|---|---|
| Care Homes | 368 | 76 |
| Social Care package | 682 | 221 |
| Sheltered Accommodation | 557 | 306 |
| Independent - alone | 5500 | 2784 |

| Identified Needs | Number |
|---|---|
| Accessing food | 4628 |
| With basic care needs | 1203 |
| Carrying supplies inside | 1,610 |
| Dietary requirement | 1,854 |

### Children & Education

Source 2

Average School Attendance w/c 27th April 2020:

| Pupils | Number |
|---|---|
| Total pupils attending daily | 2428 |
| Children of Critical Workers | 1774 |
| Vulnerable Children | 721 |

*Please note there will be some overlap between critical workers and vulnerable children.

This week the attendance average represents Monday to Thursday only due to a technical problem with the DfE webform on Friday. 219 schools reported to the DfE that they were open supporting on average 2428 children each day, an increase of over 200 more per day than the previous week. The number of vulnerable children attending provision increased to an average of 721 and and children of key workers to 1774, a small group of children are both

# Coronavirus - Citizens and Community

## Weekly Report - 12th May 2020

**107%**
**Recycled waste compared to 2019**

**1100+ Calls**
**To LCC Covid19 support helpline**



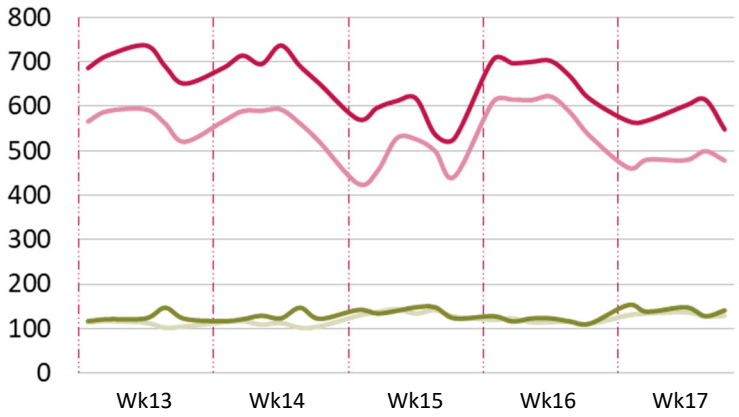
### Domestic Waste and Recycling

SOURCE 1

The Covid-19 lockdown has affected domestic waste and recycling collections. Both black and green bin weights have increased significantly when compared to the same period last year.

| Waste Type | Tonnage | Change |
|---|---|---|
| Black Bins - 2019 | 2812 | |
| Black Bins - 2020 | 3406 | 121% |
| Green Bins - 2019 | 778 | |
| Green Bins - 2020 | 3406 | 107% |

### Domestic Waste and Recycling Tonnage



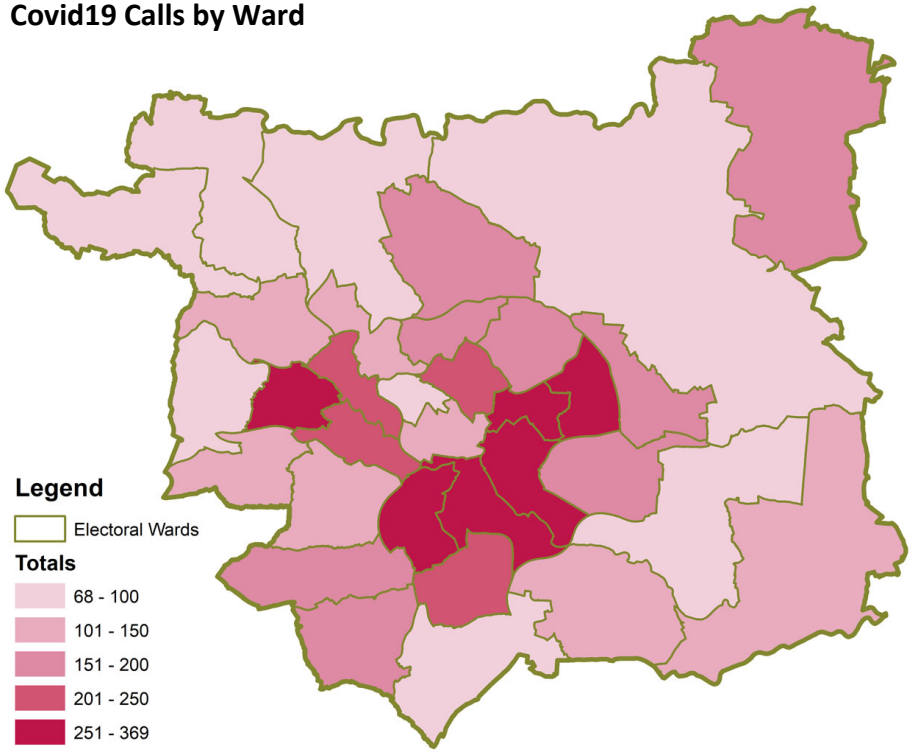

### Call Centre Data

SOURCE 1

In the week commencing 23rd April there were over 1300 calls to the Leeds City Council call centre that could be attributed to the Covid19 Pandemic. Of the call that could be categorised, the following support was provided

| Type of Assitance | Number |
|---|---|
| Food & shopping | 331 |
| Food parcel | 468 |
| Prescription | 226 |
| Fuel | 51 |
| ASC | 0 |
| Personal Products | 13 |
| Dog walking | 5 |
| Befriending and reassurance | 39 |
| TOTALS | 1133 |

### Covid19 Calls by Ward




Sources:
1) Leeds City Council 11/5/20

# Coronavirus - Economy and Business

## Weekly Report - 12th May 2020

**472 Grants** for businesses issued this week

**£194 Million** To support C.Tax payers & businesses

**Cash flow remains the key challenge for businesses**



## Economy and Business

SOURCE 1

The main issues facing businesses remain the same as in previous weeks, with cash flow and access to finance the top priority. The latest national business surveys show record falls in activity across construction, manufacturing, and the dominant services sector, where 80% of firms reported falls in activity.

Small to medium-sized manufacturers in Yorkshire and the Humber are calling for greater and faster financial support from the Government due to decreasing sales, production volumes and the prospect of job cuts. The region's latest Manufacturing Barometer, which surveyed 82 firms in the region, saw 85% of respondents experiencing a significant decline in production volumes, while a similar number (83%) are expecting sales to drop over the next six months.

The Council continues to pay out grants to those who qualify either through the Small Business Grant Fund or the Retail, Hospitality and Leisure Grant Fund immediately. The latest figures available (10th May) indicate a total of 10,334 grants valued at £127,535,000 had been paid. The Council is continuing to work through the more complex cases ensuring monies are paid as quickly as possible.

Perhaps reflecting the speculation regarding easing of lockdown over the last week, there are early signs of increased economic activity, with footfall and traffic showing slight increases, particularly at rush hour and weekends. The weekly British Chamber of Commerce survey showed the vast majority of firms say they will require three weeks or less to prepare to restart operations alongside any loosening of the UK lockdown. Smaller businesses may be able to restart operations more quickly, with 64% of those employing fewer than 10 people saying they would need less than one week.

The latest intelligence from our interactions with business confirm that the Government's newly announced Bounce Back Loans scheme has been positively received. Focus continues to shift to safe re-opening and managing social distancing, firms believe staff confidence in coming out of lockdown will be crucial, with some identifying questions around employers' liability in managing a safe return to some form of normality.

Today the ONS published analysis on 'Which occupations have the highest potential exposure to the coronavirus'. Women and men working in social care had significantly raised rates of death involving COVID-19. However, healthcare workers, including doctors and nurses, were not found to have higher rates when compared with the general population. Among men, a number of occupations were found to have raised rates, including: security guards; taxi drivers; bus drivers; chefs; and sales and retail assistants. The report also stated that factors such as ethnic group and place of residence could play a part in these rates.

## Finance

SOURCE 2

**Organisational impact (11/5/20)**

As reported last week, nationally the government has released £3.2 billion of non-ringfenced Covid-19 Support Grant funding to local authorities in two tranches of £1.6bn. In Leeds, the total allocation is £43.8m (£22.0m in the first tranche; £21.8m in the second). However, this falls far short of the estimated £165m full-year pressure on the council's budget as a result of additional expenditure and reduced income, leading to a real risk that the council will not be able to cover the current level of expenditure within the resources available. There is likely to be a need to make some difficult decisions in the coming weeks, considering the impact on this year's budget and the 2021/22 position.

At present, it is difficult to estimate how long it will take the authority to recover to pre-Covid-19 levels. With another delay to the Fair Funding Review recently announced as a result of coronavirus, this adds further uncertainty to local authority finances.

Councils provided an initial assessment of their cash flow and estimated full-year pressures as a result of Covid-19 to MHCLG in April and will be repeating the exercise shortly.

**Leeds Economy (11/5/20)**

To help reduce uncertainty for businesses, the planned revaluation of business rates will no longer take place in 2021

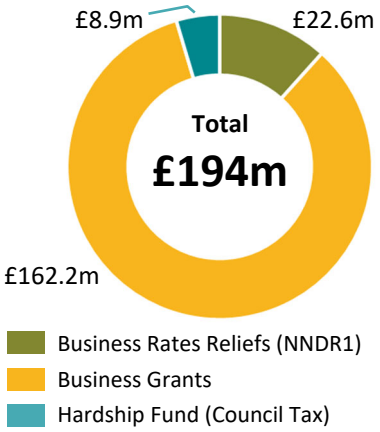
LCC has received £194m government funding to passport to businesses and council tax payers

Leeds compares extremely well against other local authorities for the % of business grants paid. As at 3/5/20, LCC had paid 75.3% (£122m) of those businesses in scope to receive a grant, above the Core City average of 63.4% (LCC ranks 2nd of 8 behind Bristol at 75.9%) and national average 74.8%.

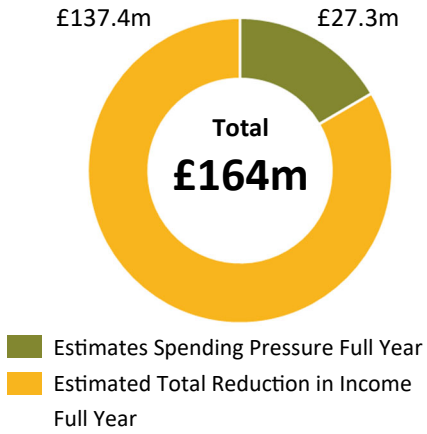
(Source: BEIS published 4/5/20)

| Business Grants | Number | Value |
|---|---|---|
| Grants issued this week | 472 | £5.62m |
| Total grants issued | 10334 | £127.5m |

### Support to businesses and council tax payers




### Estimated full-year impact on LCC expenditure and income




Sources:

1) Centre for Cities - April 2020
2) Leeds Financial Services - 11/5/20

# Coronavirus - Infrastructure & Supplies

## Weekly Report - 12th May 2020

**6.9% Foot fall**
In Leeds Centre in relation to 2019

**6.0% Foot fall**
In Leeds Station

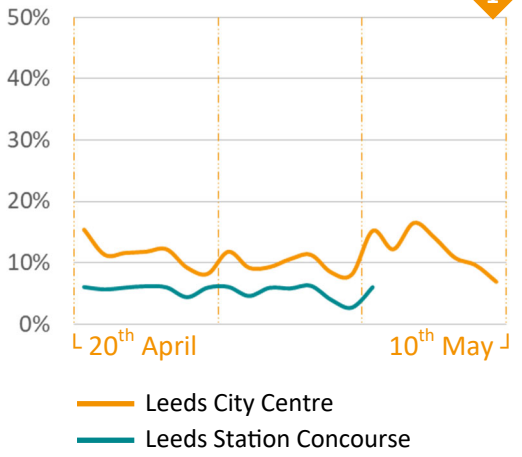
**38% Traffic**
Compared to usual expected traffic flow



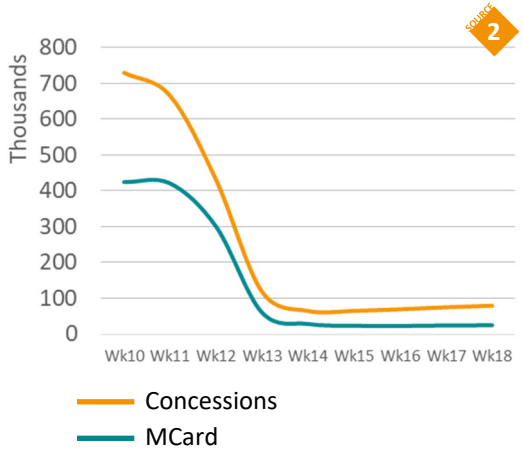
### Travel

Patterns of travel remain extremely subdued, though some suggestion that city centre footfall has clicked up.

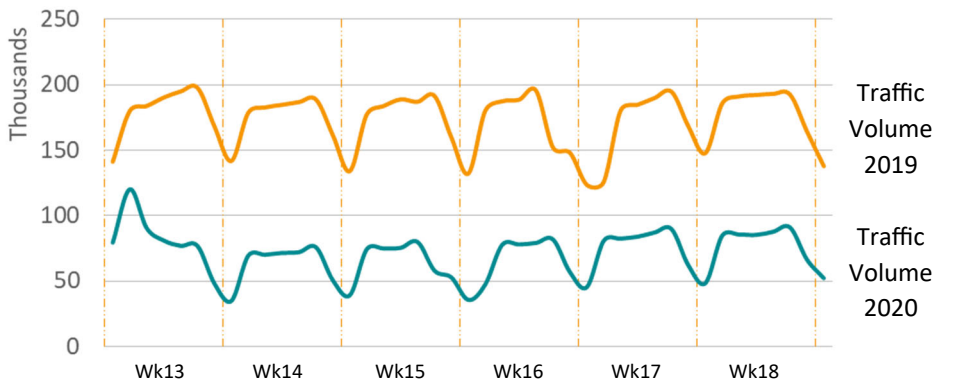
### Percentage of Expected Footfall




### MCard purchases and Concessions



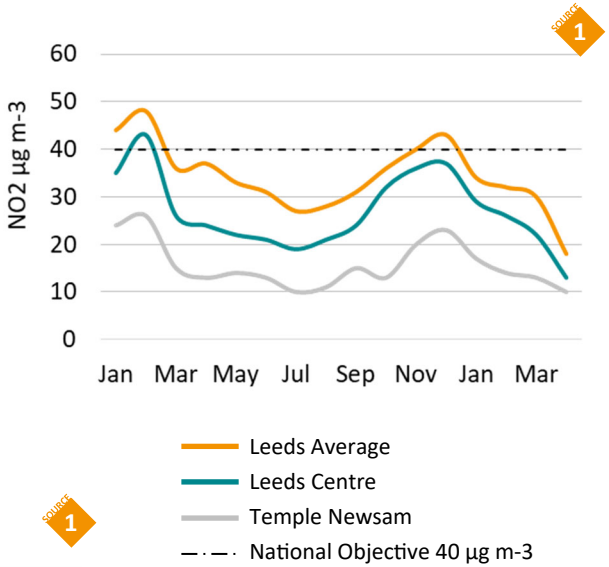

### Two-way 24hr Traffic (5 Radials)



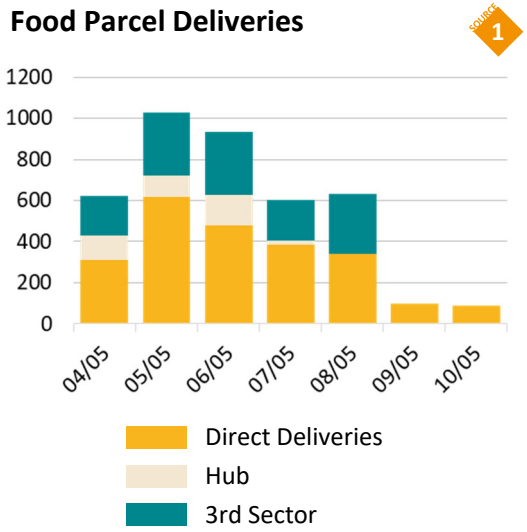

### Leeds Air Quality

The plot to the right shows the monthly mean Nitrogen Dioxide (NO2) for all the Leeds air quality monitoring sites. NO2 is one of the main pollutants of concern from vehicle emissions. The effect of the lockdown shows a dramatic reduction across all sites in Leeds and the City Centre area.

Temple Newsam Park is included to illustrate the approximate background levels of NO2 away from busy road networks




### Food Parcel Deliveries




### PPE Supplies

Reflecting the national picture, there a significant shortages of PPE.

We are aiming to develop city-wide analysis of the PPE stock for inclusion in the dashboard.

Sources:

1) Leeds City Council - 11/5/20
2) West Yorks. Combined Authority - 11/5/20

# Coronavirus - Organisational

## Weekly Report - 12th May 2020

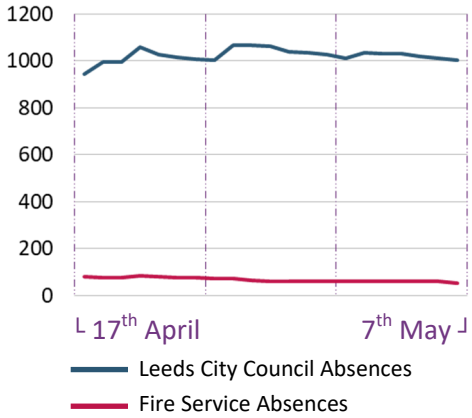
**7% LCC staff** Declaring Covid19 absence from work

**4% Fire staff** Declaring Covid19 absence from work

**3-10% Health** staff declaring Covid19 absences



### Covid related workforce absence




### Leeds City Council

Since the 1st of March a total of 2,832 staff have been absent due to a Covid related issue, of which 1,842 have since returned to work. 919 were due to sickness absence, of which 852 have since returned to work.

At the 7h May, 1003 staff are currently absent due to Covid related issue, of which 74 are sick and 929 are isolating (without access or suitable role to work from home), representing around 7% of the organisation.

### Fire Services

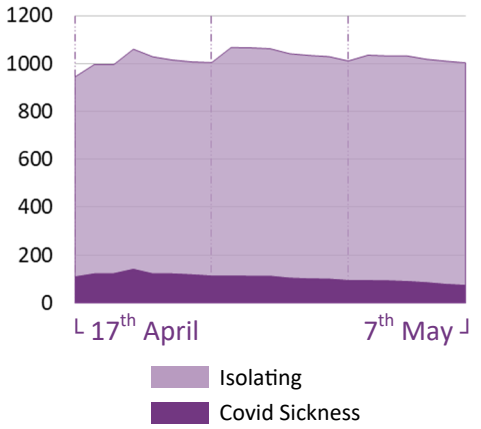
As of the 9th May, 55 staff are currently absent due to Covid related issue, of which 5 are currently sick and 50 are isolating (without access or suitable role to work from home), representing around 4% of the organisation.

### Health Care Services

As of the 11th May, Absenteeism remains at around double the rate for the three health care providers when compared to April 2019, although overall workforce absenteeism trend remains downward.

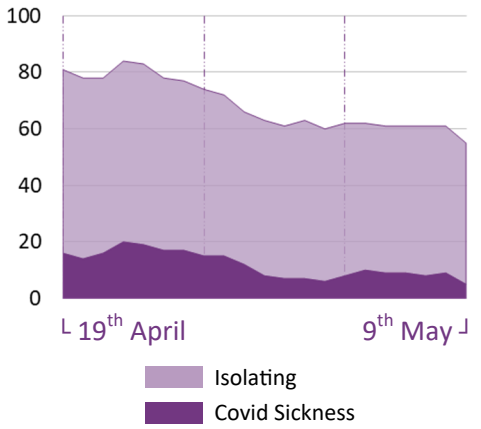
### Leeds City Council absences

SOURCE 1



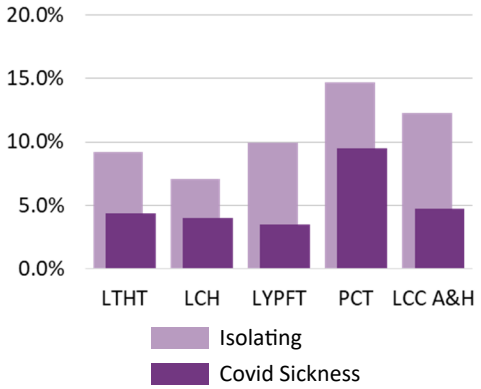

### Fire Service absences

SOURCE 2




### Health Care Services absences

SOURCE 3




Sources:

1) Leeds City Council 07/05/20
2) West Yorks. Fire Service - 09/05/20
3) Leeds Teaching Hospital Trust - 11/05/20

# Coronavirus - Communications & Media / Policy Announcements

## Weekly Report - 12th May 2020

**12500 Visits to Covid19 guidance web pages**

**"Your NHS is still here for you" comms message**



### Website Visits

12.5K visited the COVID information web pages, of which over half were new users (similar to the previous week).

The open rate for GovDelivery email bulletins, which are sent out to 113K residents, continued to decrease with a large drop from 40% to 30%.

### Council/others

Communicating services coming back online: garden waste already announced; plans to re-open car parks in parks but not playgrounds.

Further updates and public information/engagement to follow once government guidance for Phase 2 has been reviewed. Messaging to be developed locally around safety.

Monitoring public opinion/behaviour around household waste site re-openings – so far has gone down well and people using booking system and avoiding queues.

Daily interviews with social care staff in this week's YEP to spotlight them as hidden key workers

Further proactive work: domestic violence support; Connecting Leeds work on Park Row; continuing support of food distribution programme and volunteering; 50 year anniversary of Leeds twinning with Dortmund; 75th anniversary of VE Day; cycling: measures to support physical distancing for people walking and cycling across Leeds/ temporary cycle safety improvements to be installed along Kirkstall Road

### Health

Continue to deliver daily operational communications bulletin across the Trust for all staff

Working with the BME staff network to support staff from BME backgrounds amid the current concerns around the impact of Covid-19 on these communities

Developing plans for how communications can support the Trust, and staff, as it moves into the second phase of this pandemic and engage with patients and the public around the restart of urgent procedures

Supporting the 'your NHS is here for you' campaign to encourage people to attend for emergencies at the hospital

Taking time to celebrate international day of the midwife and international day of the nurse and also the efforts of staff to make VE Day a celebration – despite the current challenges

Continue to push social distancing messages across the Trust and particularly on Thursday evenings

Developing messaging for safety around Phase 2 of government response

**5 May 2020**

Working parents eligible for government childcare offers will remain eligible if their income drops below the threshold due to Covid-19, or increases above the threshold in the case of critical workers.

Source: www.gov.uk (webpage)

Councils encouraged to re-open household waste and recycling sites if social distancing can be adhered to. Guidance issued on how to do this safely.

Source: www.gov.uk (webpage)

**6 May 2020**

26 councils, including Leeds, pledge their commitment to continuing essential building safety works where safe to do so.

Source: www.gov.uk (webpage)

Care Workforce app launched to provide support for adult social care workforce in England.

Source: www.gov.uk (webpage)

A re-evaluation of business rates scheduled for 2021 has been postponed.

Source: www.gov.uk (webpage)

**7 May 2020**

Guidance issued for small-scale manufacturers that wish to produce PPE.

Source: www.gov.uk (webpage)

Pension Credit claims can now be made online to assist self-isolating or shielded pensioners.

Source: www.gov.uk (webpage)

**9 May 2020**

£250m emergency funding announced by government to support active travel in England. Statutory guidance also issued to councils on reallocating road space to pedestrians and cyclists. LCC has announced a number of measures this week.

Source: www.gov.uk (webpage)

Source: www.leeds.gov.uk (webpage)

**10 May 2020**

Prime Minister announces change in lockdown rules- those who cannot work from home should return to work, but should avoid public transport if possible. People can have unlimited outdoor exercise, and a provisional roadmap is set out for the re-opening of schools and businesses.

Source: www.gov.uk (webpage)

# Running a safe city, whilst living with COVID-19

Leeds City Council

Voluntary Action Leeds
Supporting Communities Together

NHS

**We need a phased return to a new normal in the city, so that everyone is safe within the national Plan for Recovery. Isolation, testing, contact tracing, and managing local outbreaks are key to continuing to protect the most vulnerable, while supporting businesses to return and be COVID-19 secure.**

## During this time, please:

Stay at home if you can.

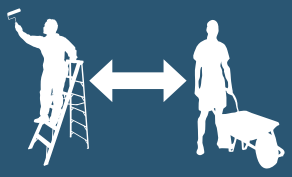

Maintain social distancing if you go out.


Wash your hands regularly and for 20 seconds.

Stay at home and isolate if you or anyone in your household has symptoms.

Limit contact with other people.

Work at home if you can.



Go to work if it is safe and you can maintain social distancing.

Only use public transport where necessary, and wear a face covering.

Continue to stay at home if you are shielded.

**And remember that the NHS is still here for you if you need treatment or have worries about your health.**

## We need everyone to play their part for the city to run safely. This means:

**Safe travel** ensuring the safe use of highways and public transport and encouraging active travel where possible.

**Safe public spaces** in communities, district centres and the city centre.

**Safe delivery of services** including health and social care, and other public services.


**Safe education** as more children and young people return to schools, colleges and nurseries.

**Safe working**, with physical distancing in workplaces and coordination between large employers in the city to avoid peaks of movement.

**For current information :** leeds.gov.uk/coronavirus LeedsCC_News



**Stay safe. Save lives.**

# Annex E – Corporate risk LCC 5: Coronavirus pandemic (COVID-19) – May 2020

| Corporate risk | | Current risk evaluation | | | Target risk evaluation (by summer 2020) | | |
|---|---|---|---|---|---|---|---|
| **Title** | **Coronavirus: threat to life, health, wellbeing and the economy** | **Probability** | **Impact** | **Rating** | **Probability** | **Impact** | **Rating** |
| **Description** | **Risk of fatalities and serious illness, significant disruption to the city and to council services in the short- to medium-term and long-term negative economic impact as a result of the coronavirus pandemic, potentially greater impact on more vulnerable and disadvantaged.** | **5** (Almost certain) | **5** (Highly significant) | **Very High** | **3** (possible) | **3** (moderate) | **High** |
| **Accountability** | **Risk owners:** Cllr Blake (Leader) and Tom Riordan (Chief Executive)<br>**Delegated owners:** Directors and Executive members<br>**Key contact:** Mariana Pexton (Chief Officer, Strategy & Improvement) | **Monitoring** | | **Best Council Plan implications** | | | |
| | | **Last review date** | **Next review date** | This risk impacts upon all ambitions and priorities for the city and the organisation set out in the council's corporate plan | | | |
| | | 23/4/20 | 19/5/20 | | | | |
| **Management review and action – systematic update monthly for Executive Board reporting and reviewed regularly by SCG Gold, CLT and Executive Members given dynamic context. More detailed risk approaches being used at more detailed levels.** | | | | | | | |

| **Strategic** | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • Ensuring effective planning and monitoring<br>• Ensuring clear governance – Leeds and West Yorkshire, Regional and National<br>• Maintaining effective, public engagement and support<br>• Lockdown restrictions may need to be re-imposed following initial easing<br>• Major challenge around operating the city centre in line with updated social distancing requirements | • Overall plan in place and regular review<br>• Multi-agency governance in place and regular review<br>• Clear approach to engagement – public, political, partners, staff, trade unions | • Continually improve clarity of governance and reporting arrangements, including detail below overall plan<br>• Evaluate engagement approach is effective<br>• Increasingly explicit shift towards recovery<br>• Best Council Plan outcomes and priorities are being reviewed and updated to reflect implications of the pandemic on the city and the council.<br>• Taking account of the lessons learned from the pandemic (local and national)<br>• Influencing national developments to help ensure they are effective |

| **Health and Social Care** | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • Increased death caused by COVID-19 (includes deaths in care homes and home deaths as well as hospitals)<br>• Care Home sustainability<br>• Increased hospital admissions caused by COVID-19<br>• Additional pressure on health and social care services<br>• Other health issues caused by inevitable focus on COVID-19<br>• Worst affected are those most vulnerable<br>• People with non-coronavirus health issues don't report them to their GPs e.g. chest pains, mini strokes. | • Leeds Teaching Hospitals Trust (LTHT) plans, plus Nightingale Hospital<br>• Additional focus on discharges<br>• Changes in access to services e.g. GP practices and other services | • Ensure focus of recovery plan is on the most vulnerable and consider best practical approach to progress this<br>• Focus on patients no longer accessing services<br>• Detailed service planning for new normal<br>• Provide advice, information and resources to schools, parents and carers to support access to food, Personal, Social and Health Education (PSHE) and children's social, emotional and mental health (SEMH) needs.<br>• Contribute to the development and implementation of new measures to test, trace and control the outbreak. |

| **Citizens and communities** | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • School closures and impact on educational attainment and progression<br>• Risks arising from the phased reopening of schools e.g. difficulty maintaining social distancing, infection spread, Trade Union concerns not addressed.<br>• Safeguarding children from risk of significant harm (child sexual exploitation, online sex abuse) | • Schools providing online tuition<br>• Tracking of children and partnership working<br>• Promoting contact details for domestic violence help<br>• Active support for 3rd sector and lobbying for national support | • Supporting Leeds school and learning community to minimise disruption<br>• Adapting practice and process to ensure vulnerable children continue to be identified, assessed, supported and 'seen/visited'<br>• Key safeguarding stakeholders working together adapting/updating child protection plans and other measures to ensure they remain robust. Weekly Bronze meetings. |

| Citizens and communities | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • Increase in levels of domestic violence<br>• 3rd sector resilience / sustainability problems<br>• Extremist narratives<br>• People ignoring national lock-down and social distancing guidance<br>• Provision of emergency food struggles to meet demand as a result of reduced food supply and/or fragility of the infrastructure which relies heavily on volunteers and 3rd sector organisations<br>• Inequalities relating to COVID-19<br>• Problems maintaining social distancing once public spaces reopen | • Daily intelligence report introduced and informing prioritisation of resourcing. | • Operation Encompass remains in place. This connects the police with schools to ensure better outcomes for children subject to, or witness to, domestic violence<br>• Major West Yorkshire public relations and communications initiative on domestic violence<br>• Guidance on dealing with extremist narratives circulated to key people<br>• Relevant teams proactively working together to enforce adherence to lock-down guidance and requirements<br>• Liaison with food partners to integrate and reduce duplication. Promote donations<br>• Focus on understanding inequalities impact from range of perspectives to plan accordingly |

| Business and economy | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • Mass job losses<br>• Significant increase in business failure due to the impact of lockdown restrictions<br>• Gaps in central government interventions to support businesses leading to increased business failure, higher unemployment and a deeper recession<br>• Extended lockdown period may result in increased damage to the national and local economy, a deeper recession and an increase in poverty across Leeds<br>• Acceleration of economic trends including automation and digital transformation<br>• High numbers of people infected with the virus or self-isolating and unable to work<br>• Employees and consumers lack confidence in the safety measures in place in public spaces, including public transport as restrictions are lifted in advance of a vaccine leading to an extended hit to productivity and a limited recovery<br>• Businesses may struggle to adopt new requirements for the workplace e.g. social distancing for customers, staff workspaces and PPE. | • Matching people to jobs where growth<br>• Lobbying for an extension of the Job Retention Scheme beyond June and a phased withdrawal of support.<br>• Efficient processing of payment of grants, ongoing engagement, support and advice.<br>• Mobilise new Local Authority Discretionary Grant Fund announced on the 2nd May to support businesses unable to access current grants schemes once government guidance is received.<br>• Maintain effective liaison with business, specifically representative bodies to understand impact on local economy<br>• The wider council working with education providers to ensure that there are plans in place for re-opening. | • A clear exit plan for the lockdown is needed that can be implemented quickly, allow the economy to get moving again whilst also managing pressures on the NHS<br>• Building capability and capacity to understand how the economy will begin to recover and reshape<br>• Supporting small businesses through the allocation of discretionary fund payments<br>• With Jobshops closed, Employment and Skills has continued delivering employment support programmes with check-ins, online learning, job searches, CVs and matching to vacancies by Employment Advisors.<br>• New customers, and referrals by DWP, can visit Leeds Employment Hub website for support to re-enter the labour market.<br>• Promotion of current vacancies continues via the council's webpages and social media.<br>• Leeds MicroBusiness Support Service support to small businesses, independents and retail sector.<br>• A rapid review of the council's Inclusive Growth Strategy has been initiated.<br>• Working Group considering phased and staged working in relation to transport and workplace attendance.<br>• A new Bronze Group has been formed with a strong focus in developing multi-agency responses to ensure the public can safely access services, amenities and support. |

| Infrastructure and supplies | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • Safe transport not provided when needed (e.g. key workers)<br>• Public transport struggles to cope with matching demand pressures and social distancing / face covering requirements<br>• Increased car journeys into the city due to reduced public transport<br>• Schemes not progressed<br>• Insufficient personal protective equipment (PPE) including face coverings<br>• Supply chain failure / key supplier ceases trading<br>• Insufficient food supplies and distribution, especially in emergency for the most vulnerable | • West Yorkshire Combined Authority (WYCA) engaged and providing support<br>• Maintaining contact with major schemes<br>• Maintaining contact with key suppliers<br>• Active management of PPE supplies and compliance with the guidance<br>• Use of FareShare and promoting campaign | • Scenario planning for removal of lockdown<br>• Encourage working from home where possible to minimise travel<br>• Continued engagement with partners<br>• Continued efforts to raise PPE issues nationally and be resourceful locally |

| Organisational impact | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • Problems in maintaining the delivery of critical services as the pandemic progresses<br>• Workforce pressures: staffing levels unable to fully support critical services, threats to the Health, Safety and Wellbeing of staff, Trade Union involvement.<br>• Significant financial pressures (high levels of unexpected expenditure, reduced income) | • Ongoing assessment of business continuity plans for the council's critical services.<br>• Extensive activity on workforce<br>• Proactive approach with meeting needs of remote working | • Identification and refresh of changing workforce resource needs to reflect prioritisation.<br>• Financial management arrangements. |

| Media and communications | | |
|---|---|---|
| **Risks and issues** | **Existing actions from Response and Recovery Plan** | **Additional actions** |
| • Challenge to reach some part of the population<br>• Campaigns don't drive behaviour required.<br>• Problems maintaining clarity with new/revised communications with the public.<br>• Reputational issues from failing to communicate properly e.g. misinformation, conflicting/confusing messages or delay in circulating key messages | • Extensive approach in place | • Dedicated Communications staff support for each key area<br>• Communications channels established for Coronavirus<br>• Leeds.gov website used to communicate changes to council services and important public announcement re coronavirus<br>• Use of Infographics as an effective way of conveying messages to the public.<br>• Comprehensive social listening and monitoring to identify and highlight emerging issues, FAQs, inform our own communications, and help counter misinformation |

This page is intentionally left blank

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 0113 37 88666

**Report of Head of Democratic Services**

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

**Date: 23 June 2020**

**Subject: Coronavirus (COVID19) pandemic – Health Inequalities**

| | | |
|---|---|---|
| Are specific electoral wards affected?<br>If yes, name(s) of ward(s): | ☐ Yes | ☒ No |
| Has consultation been carried out? | ☐ Yes | ☒ No |
| Are there implications for equality and diversity and cohesion and integration? | ☒ Yes | ☐ No |
| Will the decision be open for call-in? | ☐ Yes | ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, access to information procedure rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## 1. Purpose of this report

1.1 This report provides the Scrutiny Board with specific information associated with the COVID-19 pandemic and the specific and emerging health inequalities issues now arising.

1.2 The relevant Lead Executive Board Member and the Director of Public Health have been invited to attend the meeting to provide a further verbal update on the latest position and address any specific questions identified by members of the Scrutiny Board (Adults, Health and Active Lifestyles).

## 2. Background information

2.1 The initial governance and delivery structure to drive the response to the coronavirus outbreak, including an initial Response and Recovery Plan, was considered by the Executive Board in March 2020. A further update report by the Chief Executive, which included an updated version of the Response and Recovery Plan, was then reported to the Executive Board during its first public remote meeting held on 22 April 2020 (Link to Executive Board meeting agenda 22-04-20).

2.2 During April, arrangements were also put in place for each of the Council's Scrutiny Board Chairs to receive regular briefings from their respective Lead Directors and Executive Members to review the COVID-19 response. During May, these arrangements were extended so that, on a fortnightly basis, all Scrutiny Board Members were also being engaged in those briefings (as part of remote working groups).

2.3 As part of its first public remote meeting, the Scrutiny Board (Adults, Health and Active Lifestyles) is continuing to focus its attention on how the Council and its partners are working collaboratively to support the broad range of patients, service users and stakeholders across the health and care system during such an unprecedented and difficult period.

## 3. Main issues

3.1 During the working group discussions, members of the Scrutiny Board have raised and considered a range of matters, including:

- **Access to Health and Care Services** – patient / service user access to local health and care services.
- **Capacity of Health and Care Services** – how services have responded to the COVID-19 pandemic and overall capacity to deliver services.
- **Care Homes and Homecare** – the levels of care and support provided under extremely difficult and changing / challenging circumstances.
- **Personal Protective Equipment (PPE)** – including ongoing issues around quality; the exponential rise in costs; and establishing and maintain a sustainable supply chain across Leeds' health and care system
- **Testing** – the importance of establishing and maintaining robust and reliable arrangements for testing health and care staff; testing patients / service users in health and care settings; alongside more general testing arrangements for the public.
- **Health Inequalities** and the impact on deprived communities and specific populations.
- **Collaboration and partnership working** – details of the coordinated efforts of the Council and NHS partners; alongside some of the challenges caused by a national response and how that related to / reflected local needs and priorities.
- **Rate of infection** – the issues caused by a lack of a more localised 'R' number; and the work being done to explore the possibility of establishing an 'R' number for Leeds and/or West Yorkshire.
- **Learning points and practices** – included some of the more positive impacts around changes in practice, flexible ways of working and the general increase and broadening out of the use of digital technology.

3.2 General consideration of these matters will be given under a separate item elsewhere on the agenda. The specific purpose of this report is to help the Scrutiny Board (Adults, Health and Active Lifestyles) give specific consideration to the emerging health inequalities issues now arising as a result of the COVID-19 pandemic.

3.3 To assist the Scrutiny Board, a report from the Director of Public Health providing analysis of Leeds and national data for COVID-19 cases and mortality, using comparisons of available information is presented at Appendix 1 for consideration.

3.4 To further assist the Scrutiny Board, a report from Public Health England that presents the outcome of a descriptive review of data on disparities in the risk and outcomes from COVID-19 is presented at Appendix 2 for consideration.

## 4. Corporate considerations

### 4.1 Consultation and engagement

4.1.1 An invitation to this meeting has been extended to the Executive Board Member for Adults, Health and Active Travel and the Director of Public Health, to help the Scrutiny Board (Adults, Health and Active Lifestyles) consider the issues raised in more detail.

### 4.2 Equality and diversity / cohesion and integration

4.2.1 The appended reports focus on data analysis around health inequalities and disparities in the risk and outcomes from COVID-19 for specific consideration.

### 4.3 Council policies and the Best Council Plan

4.3.1 The appended reports focus on data analysis around health inequalities and disparities in the risk and outcomes from COVID-19 for specific consideration, which may impact on specific Council policies and the Best Council Plan in short, medium and longer term.

Climate Emergency

4.3.2 There are no specific climate emergency issues highlighted in this report and appendices at this time.

### 4.4 Resources, procurement and value for money

4.4.1 There are no specific resources, procurement or value for money issues highlighted in this report and appendices at this time.

### 4.5 Legal implications, access to information, and call-in

4.5.1 This report has no specific legal implications.

### 4.6 Risk management

4.6.1 The risks related to coronavirus will continue to be monitored through the Council's existing risk management processes.

## 5. Conclusions

5.1 General consideration of City's response to the COVID-19 pandemic are considered elsewhere on the agenda. The specific purpose of this report is to help the Scrutiny Board (Adults, Health and Active Lifestyles) give specific consideration to the emerging health inequalities issues now arising as a result of the COVID-19 pandemic.

## 6. Recommendations

6.1 The Scrutiny Board is asked to consider the information presented during the meeting and determine any specific scrutiny actions and/or activity.

## 7. Background documents[1]

7.1 None.

[1] The background documents listed in this section are available to download from the council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

This page is intentionally left blank

# Analysis of Leeds and national data for COVID-19 cases and mortality, using comparisons of available information.

## Introduction

This report summarises COVID-19 cases and mortality information from various sources (NHS England, Public Health England, Office of National Statistics (ONS), and Leeds Registrations Office), comparing available data for Leeds to national data where possible. Information used to produce this report: Office of National Statistics (ONS) data from 1st March to 1st May; Leeds registrations data from 1st March to 6th May.

## Summary

- COVID-19 is a new disease and while our knowledge and understanding of it is increasing all the time, there are still things that remain unclear. The figures and data presented below give us an idea of the situation to date in Leeds and the evidence emerging from national data, but this picture will become clearer with time as more data and information come to light.

- The majority of deaths in Leeds, where COVID-19 is mentioned, are occurring in those over 65 years, with 65% occurring in those aged 75 – 89 years. This is similar to the national picture.

- National data shows a clear link between number of deaths and deprivation. Many other diseases follow a social gradient and COVID-19 is no exception.

- In Leeds there is emerging evidence of higher deaths rates in more deprived communities: there have been 37 per 100,000 COVID-19 deaths in the 10% most deprived areas of Leeds compared to 23 per 100,000 COVID-19 deaths in the 10% least deprived areas.

- Some of the local data reported here, particularly at individual middle layer super output area (MSOA) level, is based on small numbers. This makes it more difficult to interpret as the additional of one or two deaths can have a large effect on the overall picture

- A high proportion of the Leeds shielding cohort are found within the most deprived areas and 36% of Leeds care home deaths occurred in 20% most deprived areas

- There are likely to be several different ways in which deprivation could increase the risk of death from COVID-19:
    - Underlying health conditions – those in more deprived areas are more likely to have underlying health conditions, smoke, be overweight and have fewer resources and opportunities to follow healthy lifestyle advice.
    - Exposure – those in more deprived areas are more likely to be in low-paid keyworker jobs, be unable to work at home due to job commitments or financial concerns, more reliant on public transport and be living in more crowded and densely populated areas

- National data shows that BAME groups appear to be at greater risk of death from COVID-19, even when underlying medical conditions, age and socio-demographic factors are taken into account. BAME groups who are hospitalised are also more likely to require admission to intensive care than those of white ethnicity.

- The relatively small numbers of deaths and the fact that ethnicity data is not always recorded, make it difficult to draw conclusions about the link between deaths and ethnicity for Leeds. But it does appear that BAME people living in the most deprived areas are experiencing higher rates of deaths than BAME people living in the least deprived areas. This does not show a clear pattern for those of white ethnicity.

- National data suggests that men and women working in certain occupations are experiencing higher rates of deaths involving COVID-19, including those working in social care. Limited local data on deaths by occupation and ethnicity and small numbers mean it has not been possible at this time to indicate whether this holds true for Leeds.

- All data has limitations. The number of positive cases only represents those who have had a formal test whereas deaths recorded as COVID-19 includes all deaths where COVID-19 is mentioned on the death certificate and is based on the clinical judgement of the certifying doctor not just on a positive COVID-19 test results.

- This paper does not let us see the people behind these figures and the real impact COVID-19 has had and continues to have on their lives.

## 1. Mortality

We are able to monitor trends in COVID-19 mortality trends from three different sources, including local reporting from Leeds City Council registrars and national reporting.[1]

This sources are summarised in Table1 & Figure1. There are differences in these figures due to definition and the timeliness of reporting:

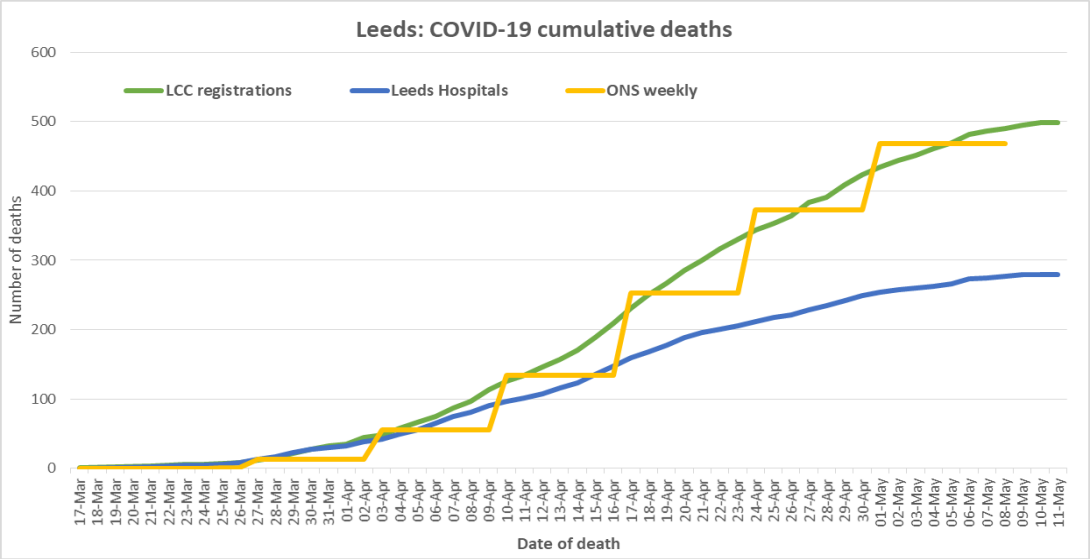
- NHS E / PHE provides daily COVID-19 test positive deaths in hospital (LTHT deaths are quoted below)
- LCC registrations include any death recorded by a Leeds registrar for a Leeds resident where the death certificate mentions COVID-19
- ONS provides all deaths for Leeds residents irrespective of location, on a weekly basis 11 days in arrears.

*Table1: Total number of deaths reported by various sources*

| **Source** | NHS E / PHE | LCC Registration | ONS |
|---|---|---|---|
| **Latest date of death** | 11th May | 12th May | 1st May |
| **Number of deaths** | 281 | 499 | 468 |

[1] Deaths by NHS Trust - NHS E website, data 1 day in arrears https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/
ONS Comparison of weekly death occurrences in England
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/comparisonofweeklydeathoccurrencesinenglandandwales/uptoweekending10april2020

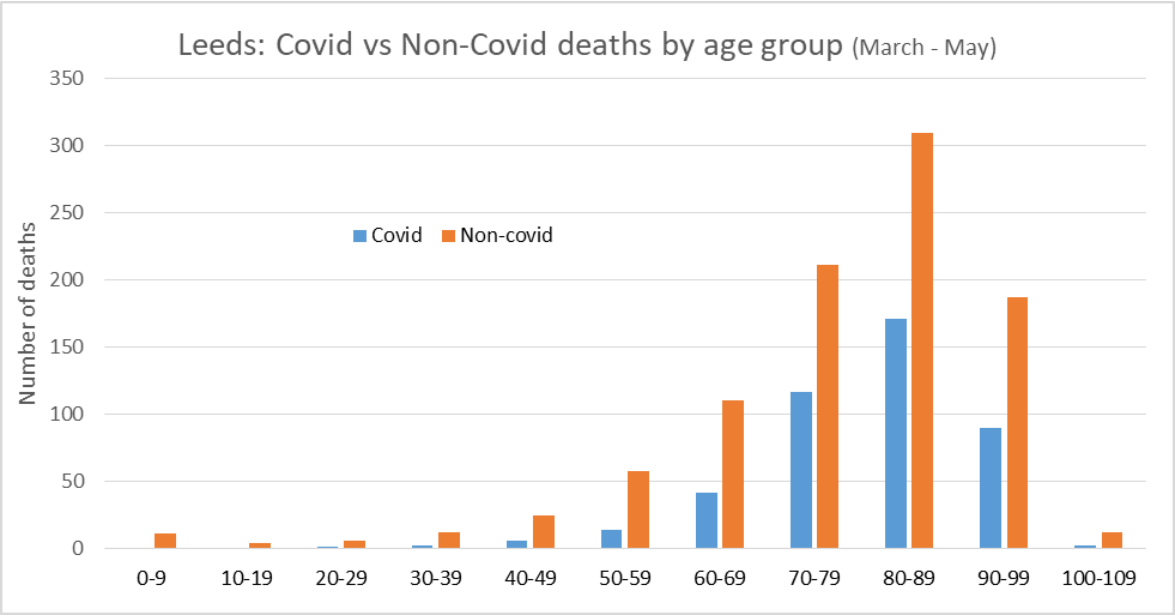
*Figure1: Leeds COVID-19 deaths cumulative*




## Local registration data

Between March 1st and May 6th 2020, there were 1,392 deaths registered with Leeds City Council, of these 32% (445) were COVID-19. ***Age group analysis shows COVID deaths in people aged between 70-89 years is higher than other age groups*** (Figure 2).

*Figure2: Leeds -COVID vs Non-COVID deaths by age group (LCC registrations)*




*Source: Leeds registrations*

Local registration data shows the majority of deaths mentioning COVID are among people aged 65 and over (399 out of 445), ***with 65% of these occurring in people aged between 75 – 89 years***.

### Location

***Latest available information on COVID deaths by place of occurrence shows a high proportion of deaths in hospitals (3 in 5 deaths) and care homes (1 in 3 deaths)*** compare to other settings (Table 2, ONS weekly deaths). Up to Week 18 (week ending 1 May 2020), 293 (62.6%) deaths occurred in hospital, 145 (31.0%) in care homes, 21 (4.5%) in private homes, and 9 (1.9%) in hospices.

*Table 2: COVID-19 deaths by place of death*

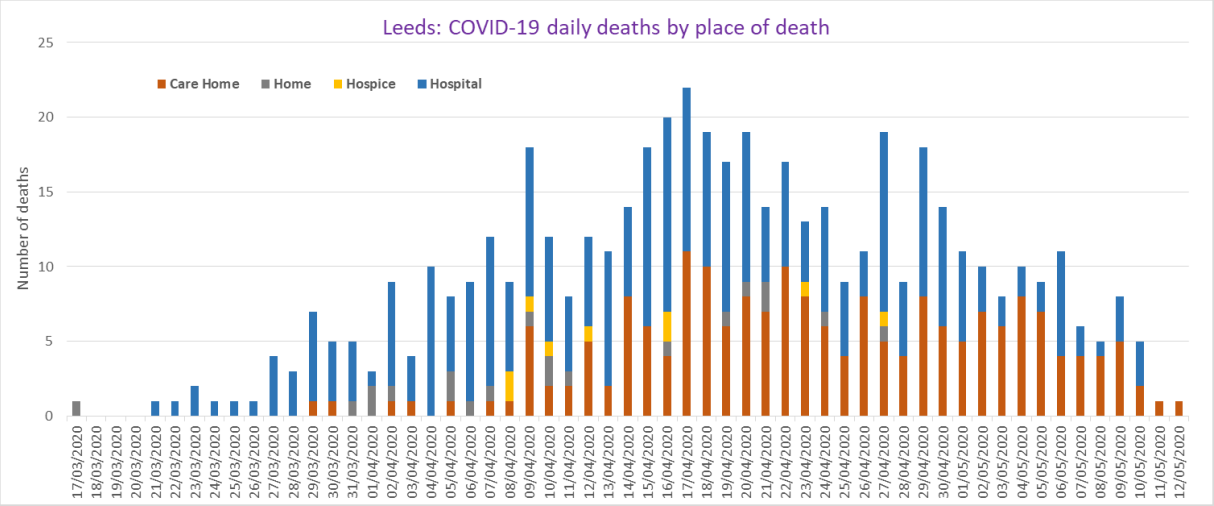
| | NHS E / PHE | LCC Registrations | | ONS weekly deaths | |
|---|---|---|---|---|---|
| Publication date | 12th May | 12th May | | 12th May | |
| **Latest date of death** | **11th May** | **11th May** | | **1st May** | |
| | n | n | % | n | % |
| Care Home | | 191 | 38.3% | 145 | 31.0% |
| Home | | 20 | 4.0% | 21 | 4.5% |
| Hospice | | 9 | 1.8% | 9 | 1.9% |
| Hospital | 281 | 279 | 55.9% | 293 | 62.6% |
| **Total COVID deaths** | **281** | **499** | **100%** | **468** | **100%** |

*Source: NHS E, ONS and LCC*

### LCC Registrar

Local registrations data trend indicates more COVID deaths occurred in hospital followed by care homes than other settings. Since April, the overall number of COVID deaths per day has declined.

*Figure 3: Leeds: COVID deaths by place of death (LCC registrations)*



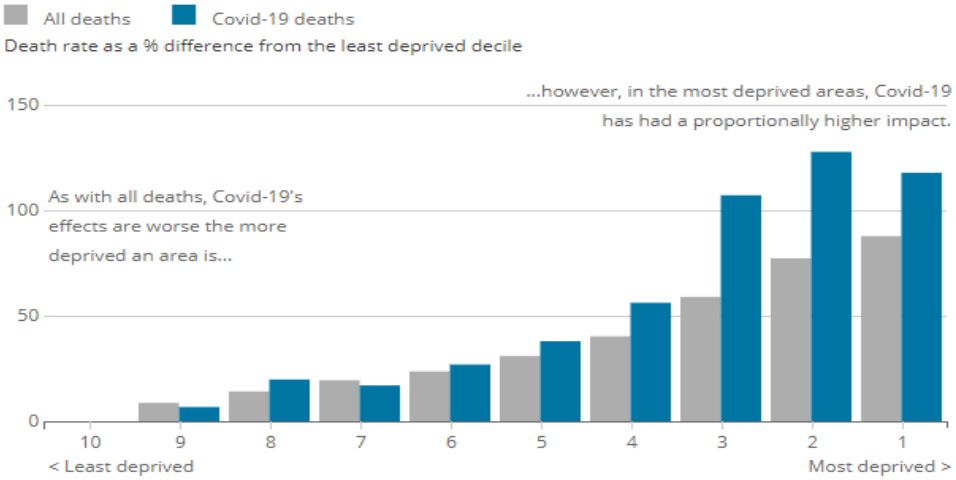

*Source Leeds registrations*

## 2. Deprivation

### ONS

Provisional data from ONS for England illustrates a higher impact of COVID-19 on mortality in areas of greater deprivation.[2] The high proportion of deaths in care homes and the location of these homes in less affluent areas may account for some of this difference, but the difference remains a concern.

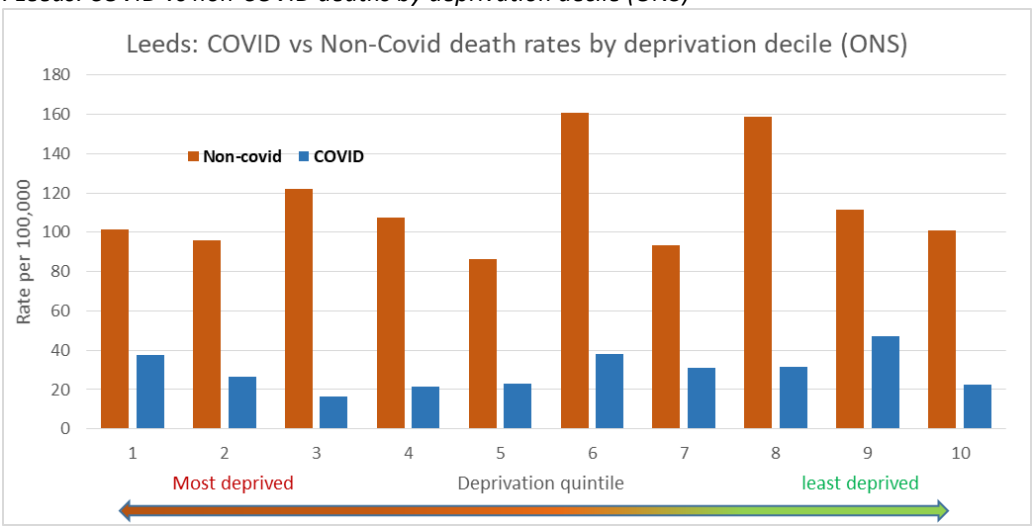
*Figure 4: England: COVID deaths by deprivation decile (ONS)*




## ONS MSOA level

***Provisional MSOA level mortality data indicates 37 deaths per 100,000 population from COVID-19 in the 10% most deprived areas of Leeds whereas the rate is 23 per 100,000 in the 10% least deprived areas of Leeds (Figure 5).***

*Figure 5: Leeds: COVID vs non-COVID deaths by deprivation decile (ONS)*




*Source: ONS*

2 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingCOVID19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april#english-index-of-multiple-deprivation

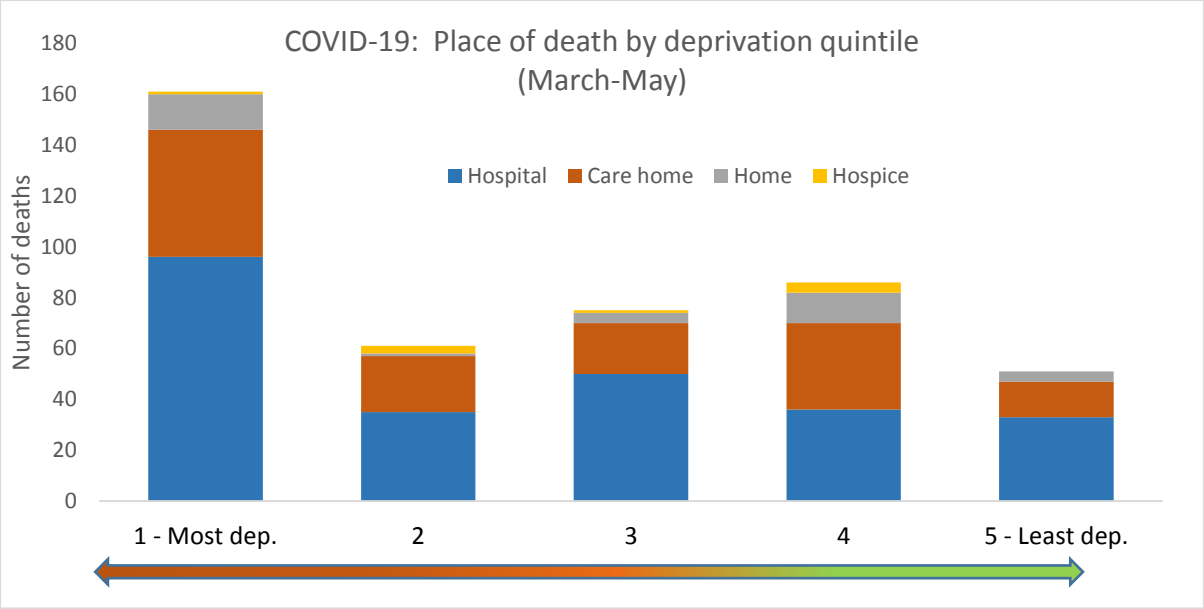
Link to national ONS data on deaths involving COVID-19 by MSOA:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april

### LCC Registrar

***The greatest number of deaths where COVID-19 is mentioned occurred in the most deprived quintile.*** Some care homes are located in areas of higher deprivation and as we know a large number of COVID-19 mentioned deaths occurred in care homes. ***However, excluding care home deaths, the proportion of deaths is still highest in the most deprived quintile.***

Overall 37% of COVID deaths are in the 20% most deprived area. 36% of care home deaths are in the 20% most deprived areas and 38% hospitals deaths are from those living in the most deprived areas. Out of 35 home deaths, 14 people (40% deaths) from the 20% most deprived areas died at home.

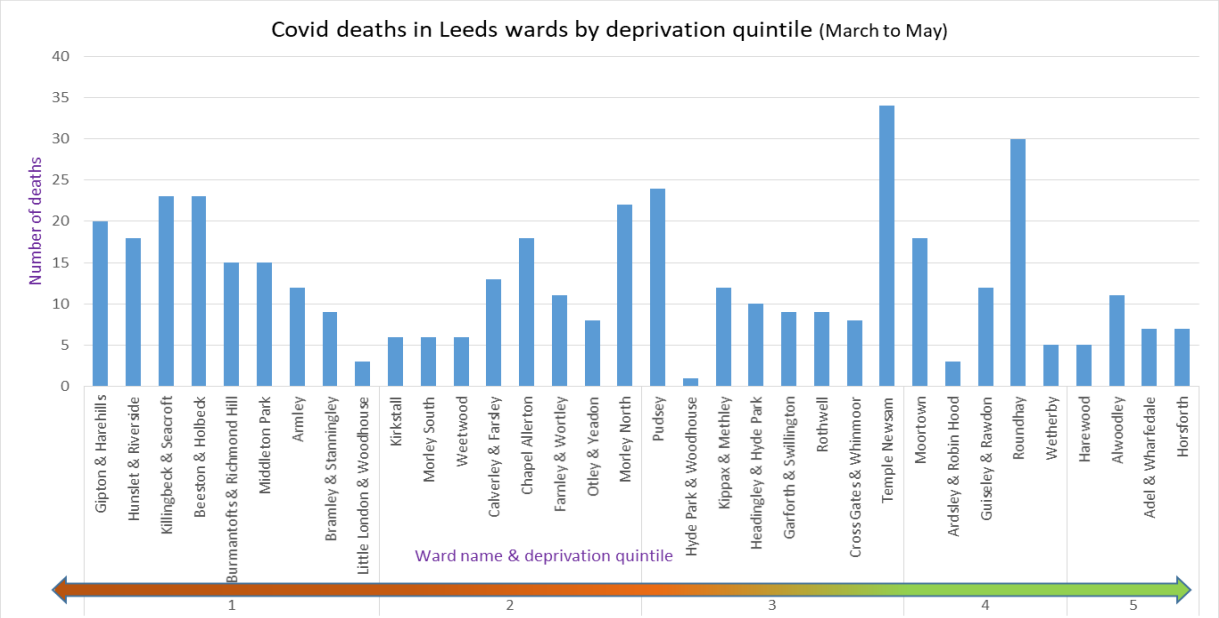
*Figure 6: Leeds: COVID deaths by place of occurrence and deprivation quintile (LCC registrations)*




*Source: Leeds registrations*

When reviewing the data by individual wards, 32% of COVID deaths (138 out of 433 deaths) were in the 20% most deprived wards, whereas only 7% deaths (30 deaths) from 20% least deprived area (Figure 7). Postcode data is not recorded on death registrations making it more difficult to match deaths to a particular MSOA or ward. Data at this level is harder to interpret due to small numbers. Other factors apart from deprivation will also influence this data for example some wards may have a higher proportion of older people or may include a care home which has experienced an outbreak.

*Figure 7: Leeds: COVID deaths in Leeds wards by deprivation quintile (LCC registrations)*




*Source: Leeds registrations*

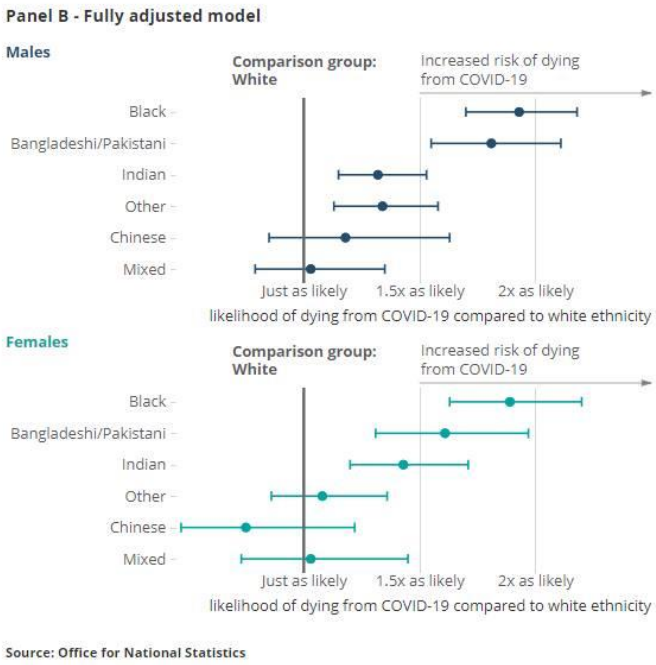
## 3. Ethnicity

### ONS

National data analysis by the ONS has concluded that "When taking into account age in the analysis, Black males are 4.2 times more likely to die from a COVID-19-related death and Black females are 4.3 times more likely than White ethnicity males and females. After taking account of age and other socio-demographic characteristics and measures of self-reported health and disability at the 2011 Census, the risk of a COVID-19-related death for males and females of Black ethnicity reduced to 1.9 times more likely than those of White ethnicity."[3] **Black and Bangladeshi/Pakistani and Indian ethnic groups have a greater risk of COVID-19 related death compared to White ethnicity**. The reasons for this are not yet clear but national work is ongoing to explore this in more detail.

3

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020#ethnic-group-differences-in-deaths-involving-COVID-19-adjusted-for-main-socio-demographic-factors



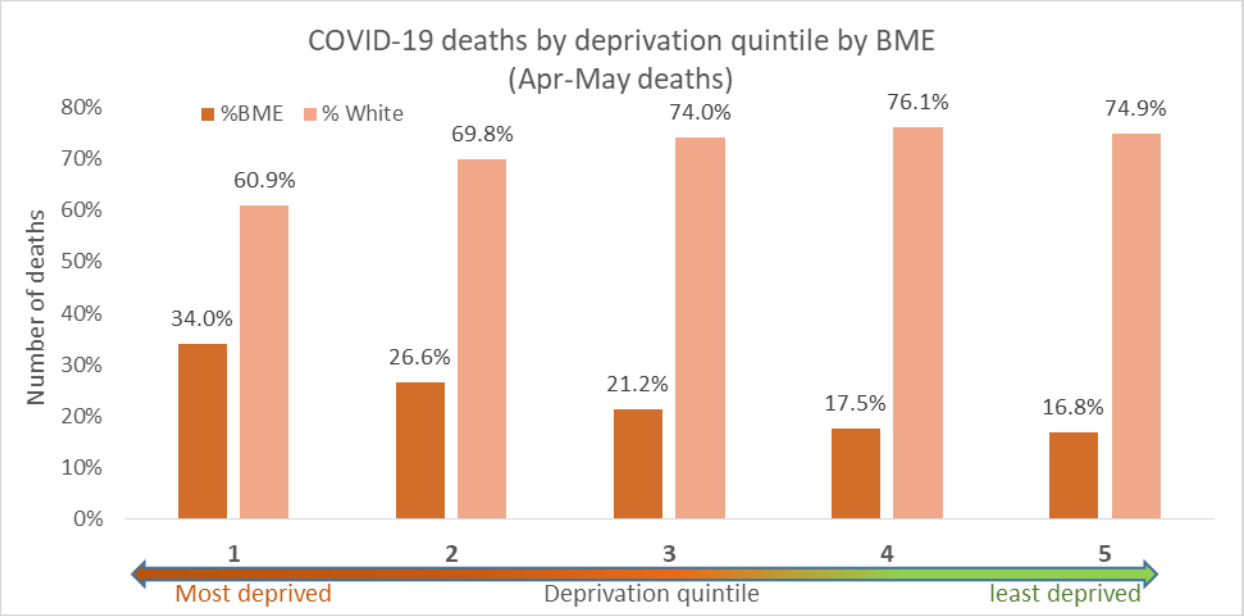

## LTHT deaths of COVID-19 positive patients

BAME people represent around 14% of the total population of Leeds. As of 11/05/20, BAME people accounted for 8.1% of all deaths from COVID-19 in hospital. At present there are insufficient numbers of deaths by ethnic group reported from LTHT to draw conclusions on health inequalities for BAME communities using local data.

## LCC Ethnicity:

***Local COVID deaths data indicates there is clear variation within Black Minor Ethnic (BME) deaths by deprivation quintile. 34% of COVID deaths in BME population from 20% most deprived area where as only 16.8% from least deprived area*** (Figure 8).

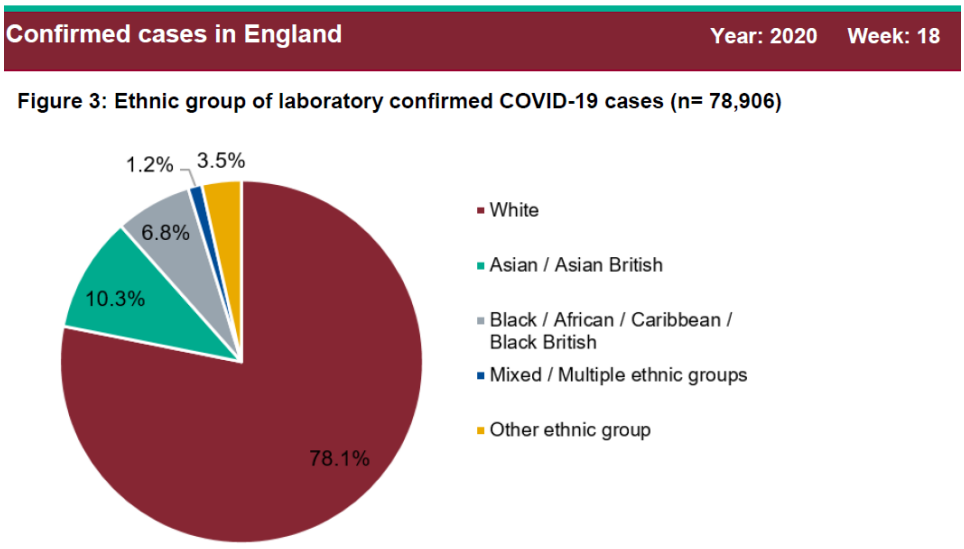
*Figure 8: Leeds: COVID deaths by Ethnicity and deprivation quintile (LCC registrations)*




*Source: Leeds registrations*

## PHE national data on ethnicity

86% of the total population of England and Wales are White, with 7.5% Asian and 3.3% Black. This suggests that Black people are over represented in numbers of confirmed cases of COVID-19 and White people are underrepresented. Year: 2020 Week: 18.[4]



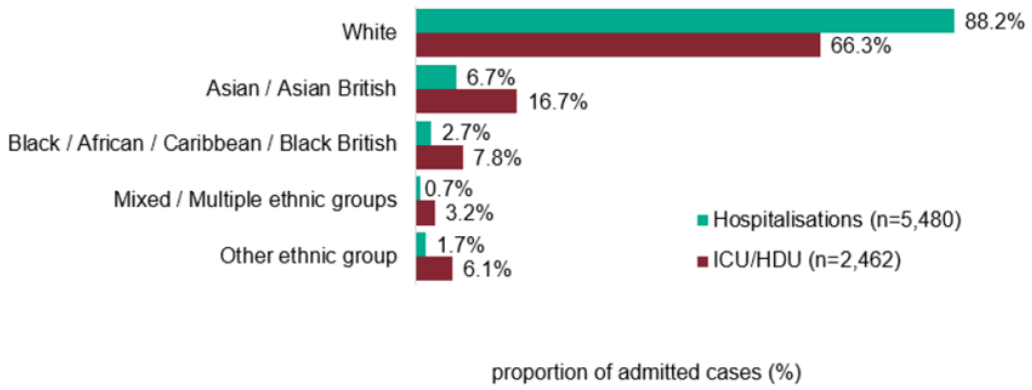

## PHE national data on hospitalisation

***Nationally a higher proportion of people from non-White ethnic groups require ICU/HDU care than the White ethnic group compared to the proportion admitted***

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882420/COVID19_Epidemiological_Summary_w18_FINAL.pdf

COVID-19 Hospitalisation in England Surveillance System (CHESS)

**Figure 16: Ethnic group of new hospitalisations (lower level of care) (n=5,480) and ICU/ HDU (n=2,462) COVID-19 cases reported through CHESS, England**

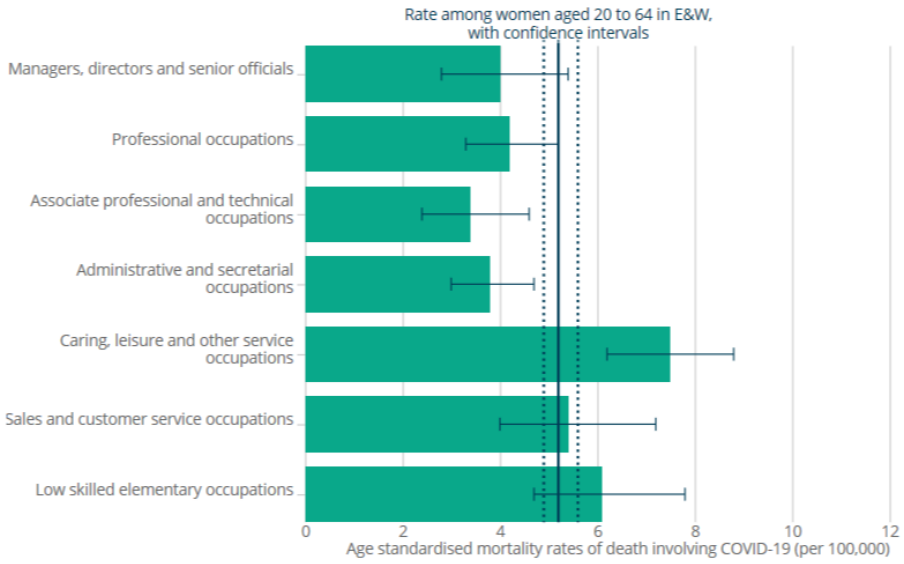


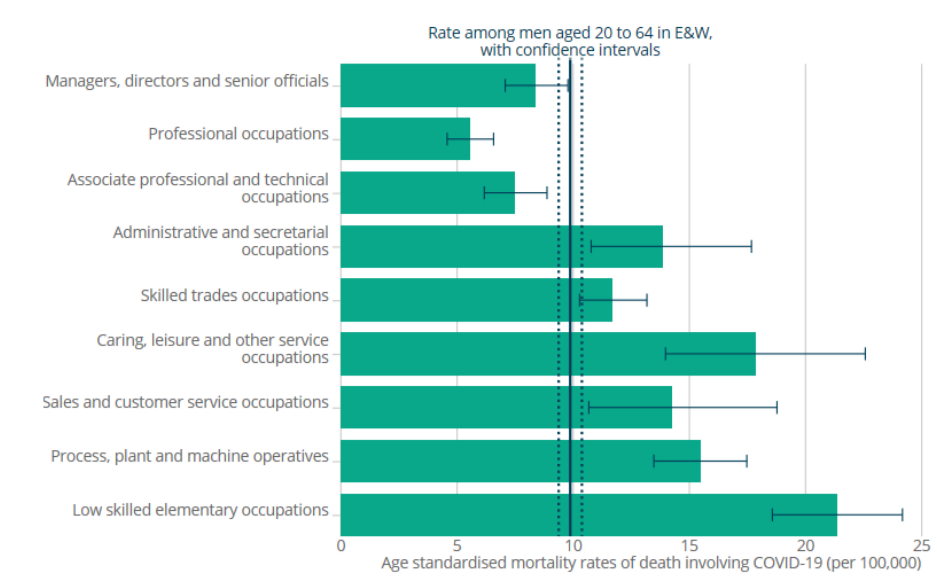

## 4. Key workers

### National data

The ONS has looked at COVID-19 deaths by occupation (where this was recorded). Elementary occupations had the highest age standardised death rates, followed by caring, leisure and other service occupations. Male road transport drivers had some of the highest rates of death involving COVID-19, for women this was highest for those in the caring, leisure and other service occupations. Rates of death for male and female social care workers were statistically significantly higher than those of the same age and sex in England and Wales.

Age-standardised mortality rates of death involving the coronavirus (COVID-19) in England and Wales, deaths registered up to, and including, 20 April 2020






### LCC registrar

***Local deaths registration data on key work groups only provides small numbers that can be readily classified as key workers.*** These indicate that 7% of Leeds COVID deaths (31 people out of 445) are in key worker groups, but this may be higher due to the difficulty in matching the information on registrations to recognised key worker roles (Table 3). Of those data retrieved on key workers for Leeds, the highest proportions are from the health and social care sector (58%) and transport (16%). It was not possible to review number of deaths by occupation and ethnicity due to small numbers and incomplete data.

*Table 3: COVID-19 deaths by key worker group*

| Key worker group | Deaths | % of key worker deaths |
|---|---|---|
| **Health & Social care** | 18 | 58.1% |
| **Transport** | 5 | 16.1% |
| **Police** | 3 | 9.7% |
| **Education** | 2 | 6.5% |
| **Bank/finance** | 1 | 3.2% |
| **Defence** | 1 | 3.2% |
| **Food/retail** | 1 | 3.2% |

*Source: Leeds registration*

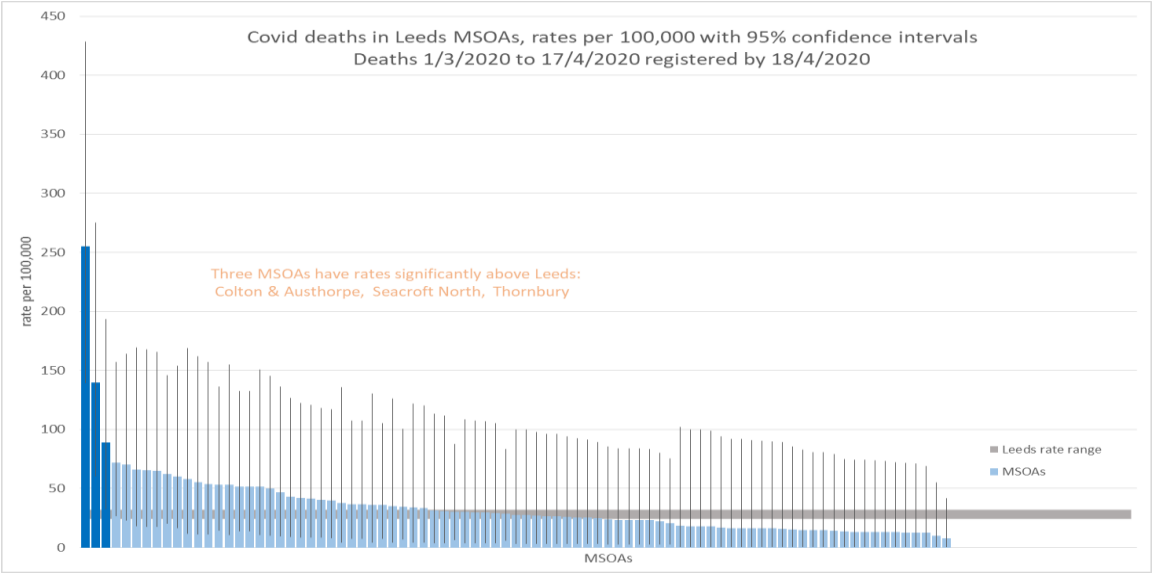
## 5. Geography

### ONS MSOA counts

MSOA level COVID death rates show the difference in death rates due to COVID across Leeds (Figure 9). Three MSOAs show significantly higher rates than the Leeds average but the numbers at MSOA

level are small, meaning that a small increase or decrease could alter the picture. Wide confidence intervals are due to small numbers.

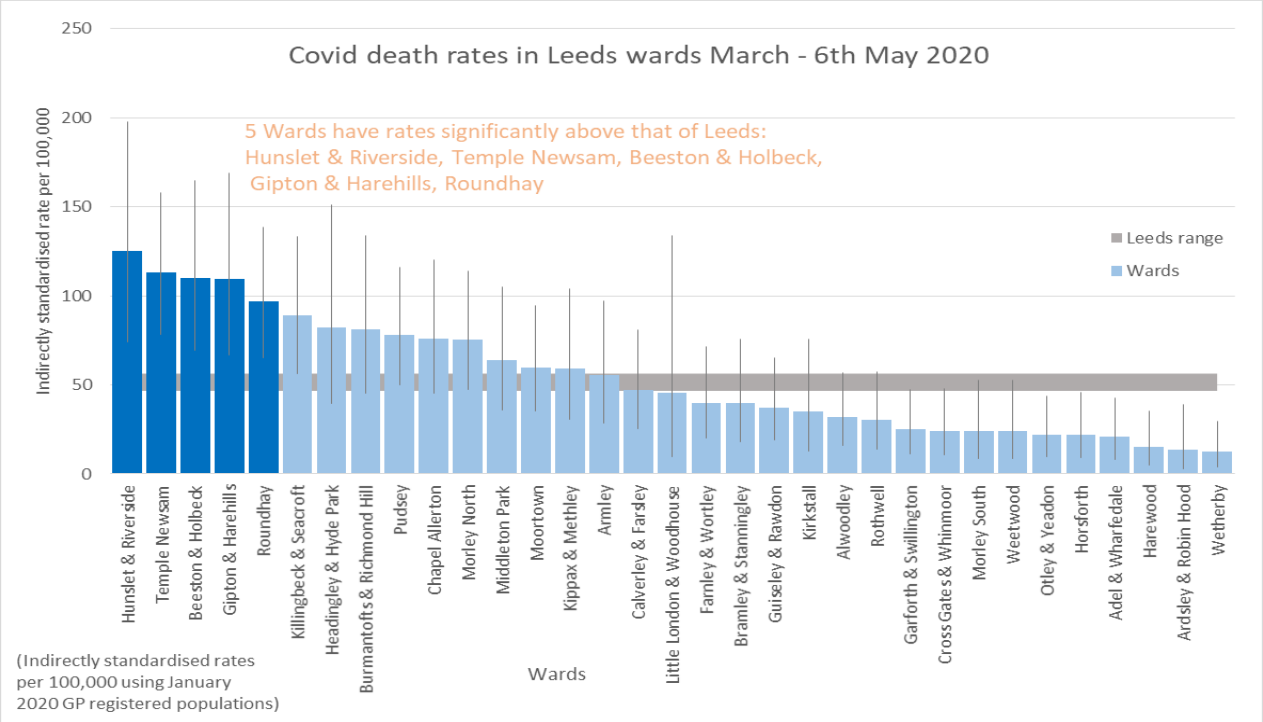
*Figure 9: Leeds: COVID deaths by MSOA (ONS)*




*Source: ONS*

***Ward level ISR (Indirectly standardised rates) shows there were 5 wards (Hunslet & Riverside, Temple Newsam, Beeston & Holbeck, Gipton & Harehills, Roundhay) in Leeds with significantly high death rates than others (Figure 10). It should be noted that three of these wards include some of the most deprived areas in Leeds and some of the numbers are small.***

*Figure 10: Leeds: COVID deaths by ward (ISR) (Leeds registrations)*




*Source: Leeds Registrations*

## 6. Shielded cohort

The number people in the shielded cohort has recently increased, local BI teams are working to understand the change in criteria for inclusion in this cohort. For the Leeds the cohort increased from 18,050 to 45,713. The number of shielded people both identified and self-registered is higher in the most deprived areas (figure 11). The proportion of people self-registering is higher in less deprived areas, suggesting there may be higher levels of both met and unmet need in the most deprived areas.

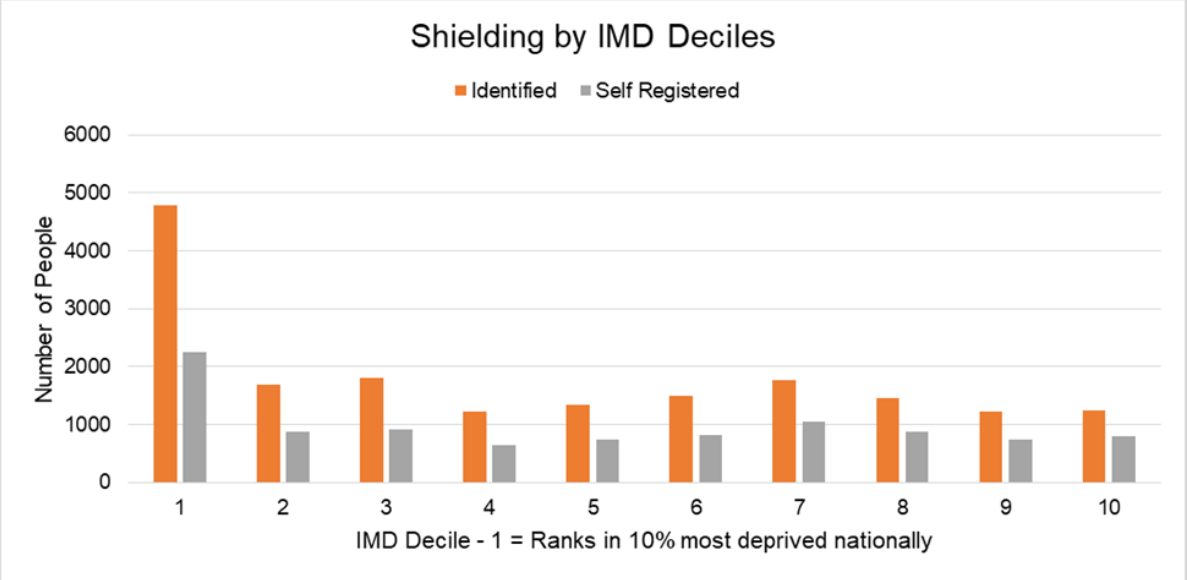



*Figure 11: Leeds: Number of people shielding by deprivation decile*

Report prepared by Suresh Perisetla, Public Health Intelligence Manager, Frank Wood, Chief Analyst and Ruth Speare, Consultant in Public Health on behalf of Victoria Eaton, Director of Public Health. 18th May 2020

This page is intentionally left blank

Public Health England

Protecting and improving the nation's health

# Disparities in the risk and outcomes of COVID-19

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Epi cell, Surveillance cell and Health Intelligence team
For queries relating to this document, please contact: coviddisparitiesreview@phe.gov.uk



Published June 2020
PHE publications
gateway number: GW-1311

PHE supports the UN
Sustainable Development Goals

# Contents

# Executive summary

This is a descriptive review of data on disparities in the risk and outcomes from COVID-19. This review presents findings based on surveillance data available to PHE at the time of its publication, including through linkage to broader health data sets. It confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them. These results improve our understanding of the pandemic and will help in formulating the future public health response to it.

The largest disparity found was by age. Among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups. These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in White ethnic groups. These analyses take into account age, sex, deprivation, region and ethnicity, but they do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences.

When compared to previous years, we also found a particularly high increase in all cause deaths among those born outside the UK and Ireland; those in a range of caring occupations including social care and nursing auxiliaries and assistants; those who drive passengers in road vehicles for a living including taxi and minicab drivers and chauffeurs; those working as security guards and related occupations; and those in care homes. These analyses do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and could explain some of these differences.

When this data was analysed, the majority of testing had been offered to those in hospital with a medical need. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected. This is important because disparities between diagnoses rates may reflect differences in the risk of getting the infection, in presenting to hospital with a medical need and in the likelihood of being tested.

Some analyses outlined in this review are provisional and will continue to be improved. Further work is planned to obtain, link and analyse data that will complement these analyses.

The results of this review need to be widely discussed and considered by all those involved in and concerned with the national and local response to COVID-19. However, it is already clear that relevant guidance, certain aspects of recording and reporting of data, and key policies should be adapted to recognise and wherever possible mitigate or reduce the impact of COVID-19 on the population groups that are shown in this review to be more affected by the infection and its adverse outcomes.

As the numbers of new COVID-19 cases decrease, monitoring the infection among those most at risk will become increasingly important. It seems likely that it will be difficult to control the spread of COVID-19 unless these inequalities can be addressed.

## Age and sex

COVID-19 diagnosis rates increased with age for both males and females. When compared to all cause mortality in previous years, deaths from COVID-19 have a slightly older age distribution, particularly for males.

Working age males diagnosed with COVID-19 were twice as likely to die as females. Among people with a positive test, when compared with those under 40, those who were 80 or older were seventy times more likely to die. These are the largest disparities found in this analysis and are consistent with what has been previously reported in the UK.

These disparities exist after taking ethnicity, deprivation and region into account, but they do not account for the effect of comorbidities or occupation, which may explain some of the differences.

## Geography

The regional pattern in diagnoses rates and death rates in confirmed cases among males were similar. London had the highest rates followed by the North West, the North East and the West Midlands. The South West had the lowest. For females the North East and the North West had higher diagnosis rates than London, while London had the highest death rate.

Local authorities with the highest diagnoses and death rates are mostly urban. Death rates in London from COVID-19 were more than three times higher than in the region with the lowest rates, the South West. This level of inequality between regions is much greater than the inequalities in all cause mortality rates in previous years.

## Deprivation

People who live in deprived areas have higher diagnosis rates and death rates than those living in less deprived areas. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females. This is greater than the inequality seen in mortality rates in previous years, indicating greater inequality in death rates from COVID-19.

High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes from COVID-19 infection in deprived areas remain after adjusting for age, sex, region and ethnicity, but the role of comorbidities requires further investigation.

## Ethnicity

People from Black ethnic groups were most likely to be diagnosed. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups. This is the opposite of what is seen in previous years, when the mortality rates were lower in Asian and Black ethnic groups than White ethnic groups. Therefore, the disparity in COVID-19 mortality between ethnic groups is the opposite of that seen in previous years.

An analysis of survival among confirmed COVID-19 cases and using more detailed ethnic groups, shows that after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced.

## Occupation

A total of 10,841 COVID-19 cases were identified in nurses, midwives and nursing associates registered with the Nursing and Midwifery Council. Among those who are registered, this represents 4% of Asian ethnic groups, 3.1% of Other ethnic groups, 1.7% of White ethnic groups and 1.5% of both Black and Mixed ethnic groups. This analysis did not look at the possible reasons behind these differences, which may be driven by factors like geography or nature of individuals' roles.

ONS reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19. Our analysis expands on this and shows that nursing auxiliaries and assistants have seen an increase in all cause deaths since 2014 to 2018. For many occupations, however, the number of deaths is too small to draw meaningful conclusions and further analysis will be required.

## Inclusion health groups

When compared to previous years, there has been a larger increase in deaths among people born outside the UK and Ireland. The biggest relative increase was for people born in Central and Western Africa, the Caribbean, South East Asia, the Middle East and South and Eastern Africa. This may be one of the drivers behind the differences in mortality rates seen between ethnic groups.

There were 54 men and 13 women diagnosed with COVID-19 with no fixed abode, likely to be rough sleepers. We estimate that this represents 2% and 1.5% of the known population of women and men who experienced rough sleeping in 2019. Data is of poor quality, but this suggests a much higher diagnoses rate when compared to the general population.

## People in care homes

Data from the Office for National Statistics (ONS) shows that deaths in care homes accounted for 27% of deaths from COVID-19 up to 8 May 2020. The number of deaths in care homes peaked later than those in hospital, in week ending 24 April.

Our analyses show that there have been 2.3 times the number of deaths in care homes than expected between 20 March and 7 May when compared to previous years, which equates to around 20,457 excess deaths. The number of COVID-19 deaths over this period is equivalent to 46.4% of the excess suggesting that there are many excess deaths from other causes or an under-reporting of deaths from COVID-19.

## Comorbidities

Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.

Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This finding is consistent with other studies that have reported a higher risk of death from COVID-19 among patients with diabetes. This proportion was higher in all

BAME groups when compared to White ethnic groups and was 43% in the Asian group and 45% in the Black group. The same disparities were seen for hypertensive disease.

Several studies, although measuring the different outcomes from COVID-19, report an increased risk of adverse outcomes in obese or morbidly obese people.

# Acknowledgements

All the analyses in this document were done by scientists working in the Epi cell, Surveillance cell and Health Intelligence team at Public Health England. A draft of this document was reviewed by the individuals and teams below, to whom we are extremely grateful:

- John Pullinger
- Professor Andrew Hayward
- Professor Keith Neal
- The Race Disparity Unit (Cabinet Office)
- PHE topic experts

# 1. Age and sex

## 1.1 Main messages

Diagnosis rates are higher among females under 60, and higher among males over 60. Despite making up 46% of diagnosed cases, men make up almost 60% of deaths from COVID-19 and 70% of admissions to intensive care units.

The rate of diagnosed cases increases with age, but the age profile is markedly different among those in critical care. The largest number of patients in critical care come from age groups between 50 and 70 for both males and females and only small numbers aged over 80.

When compared to all cause mortality in previous years, deaths from COVID-19 have a slightly older age distribution, particularly for males. Between the ages of 40 to 79, the age specific death rates from COVID-19 among males were around double the rates in females compared with 1.5 times for all cause mortality in previous years.

A survival analysis looked at people with a positive test, and those 80 or older, when compared with those under 40, were seventy times more likely to die. These are the largest disparities found in this analysis. Working age males diagnosed with COVID-19 were twice as likely to die as females.

The majority of excess deaths (75%) occurred in those aged 75 and over. COVID-19 deaths were equivalent to 80% of the excess in every age group, except the oldest age group where this proportion is lower. There have been fewer deaths than expected in children under 15 years of age.

These findings are consistent with what has been previously reported by ONS (1) and ICNARC (2).

## 1.2 Background

Male sex and increasing age are known factors associated with COVID-19-related mortality. This was apparent from early on in the pandemic among patients in Wuhan, China (3) and evidence has since accumulated from multiple other countries (4).

Data from the Intensive Care National Audit and Research Centre (ICNARC) has consistently reported that COVID-19 admissions to critical care are mostly among men, making up 71.0% of admissions reported as of 21 May (2). Similarly, ONS reported COVID-19 age-standardised mortality rate for males (781.9 deaths per 100,000) is

significantly higher than that for females (439.0 deaths per 100,000) (1). This difference in risk is also observed in the hospitalised population; data from 16,649 COVID-19 positive patients in 166 UK hospitals between February and April 2020 showed that even after controlling for age, comorbidities and obesity, female sex was associated with a reduced risk of death (HR=0.80 (95%CI 0.72-0.89)) compared to male sex (5).

COVID-19-related mortality rates reported by ONS also increase across age groups. For males the increase is significant from 35 to 39 years and above, and for females from 40 to 44 years and above (1). This increase in mortality by age is also observed among hospitalised patients; data from the same study of 16,649 COVID-19 positive patients showed that, even after adjusting for comorbidities, sex and obesity, the risk of dying among those over 80 was almost 14 times higher than those under 50 years old (5).

It is not yet fully clear what drives the differences in outcomes between males and females. Some could be driven by different risks of acquiring the infection – for example due to behavioural and occupational factors – and by differences in how women and men develop symptoms, access care and are diagnosed, or by biological and immune differences that put men at greater risk.

## 1.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

As of 13 May, there had been 63,661 cases in males (46.4%) and 73,529 cases in females (53.6%). Figure 1.1 shows the distribution of these cases by age groups and sex.

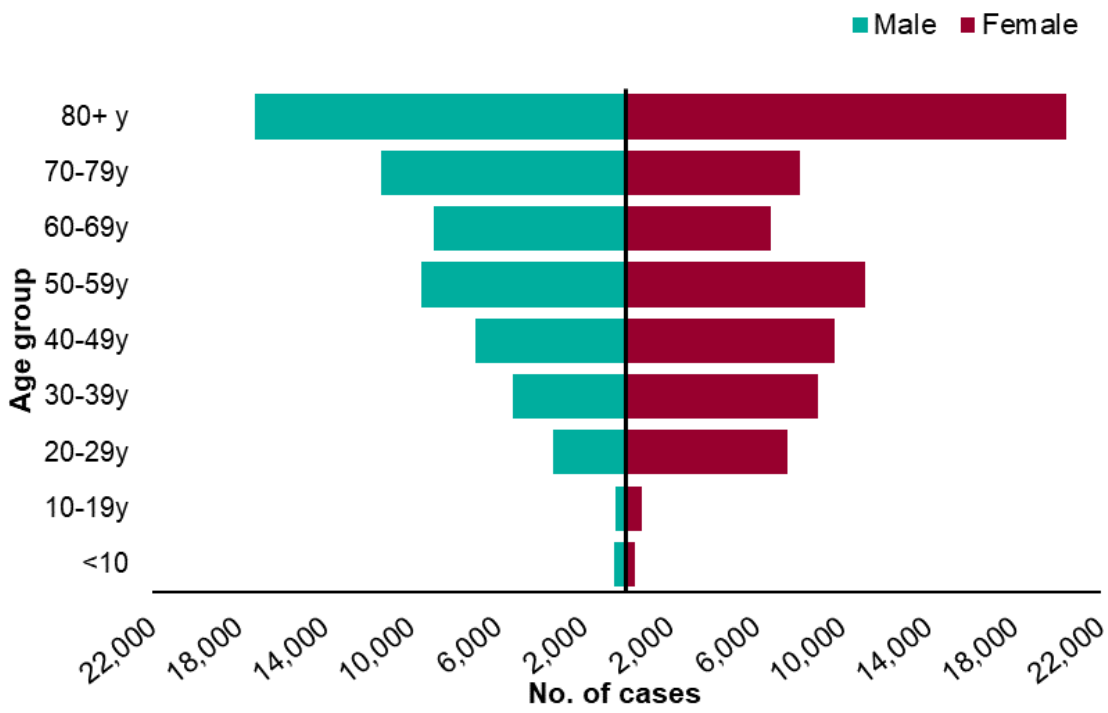



**Figure 1.1.** Age sex pyramid of laboratory confirmed COVID-19 cases as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

The age standardised diagnosis rates per 100,000 population were similar in males (256.0) and females (252.0). Among people under 60, diagnosis rates were higher in females than males, and among people aged 60 years and older, diagnosis rates were higher in males (Figure 1.2).

PHE has reported previously that among those who were tested, males were more likely to have a positive test (6). This may suggest that females were tested more often and possibly with milder disease. This could be a reflection of the higher number of females working in occupations that expose them to the infection and could explain higher diagnoses rates in working age females. Higher diagnosis rates among males over 60 may reflect worse clinical outcomes in this group.

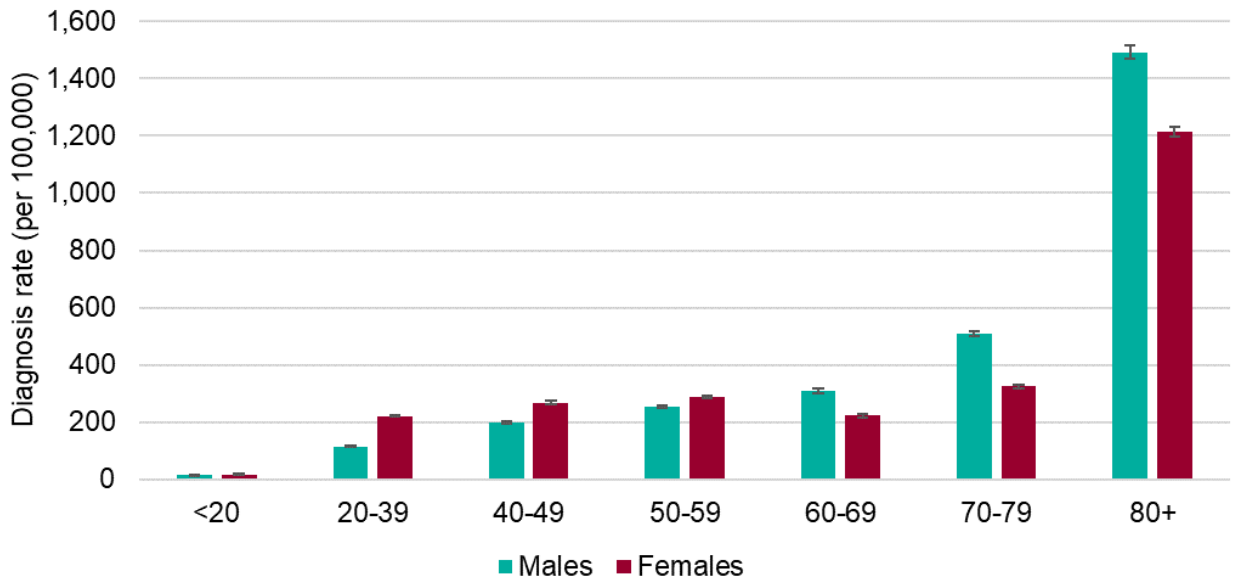



**Figure 1.2.** Diagnosis rates by sex and age as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

## 1.4 Hospitalisations

As of 19 of May, 42 trusts had reported lower level of care patients (defined as admission to any hospital ward, excluding intensive care units (ICU) or high dependency units (HDU)), and 94 trusts contributed ICU/HDU (critical care) patient data to the COVID-19 Hospitalisation in England Surveillance System (CHESS). Reporting varies by trusts and the majority of trusts in London do not consistently report to CHESS which will impact on the representativeness of the hospitalised cases. The data presented in this section have not been adjusted for this, which means findings must be interpreted with caution.

Figure 1.3 shows the age and sex distribution of COVID-19 confirmed cases in ‘lower level of care’ and in critical care. Males make up 54.4% of patients in lower level of care and 70.4% of patients in critical care.

For both sexes, the patient population is younger in critical care. Cases aged over 70 make up 65.5% and 67.6% of the patients in lower level of care among males and females, respectively; in critical care, those over 70 make up only 22.0% and 17.9% of the male and female patients, respectively. The overrepresentation of younger patients in critical care does not necessarily reflect increased severity in this group of patients alone but may also reflect critical care admission criteria.

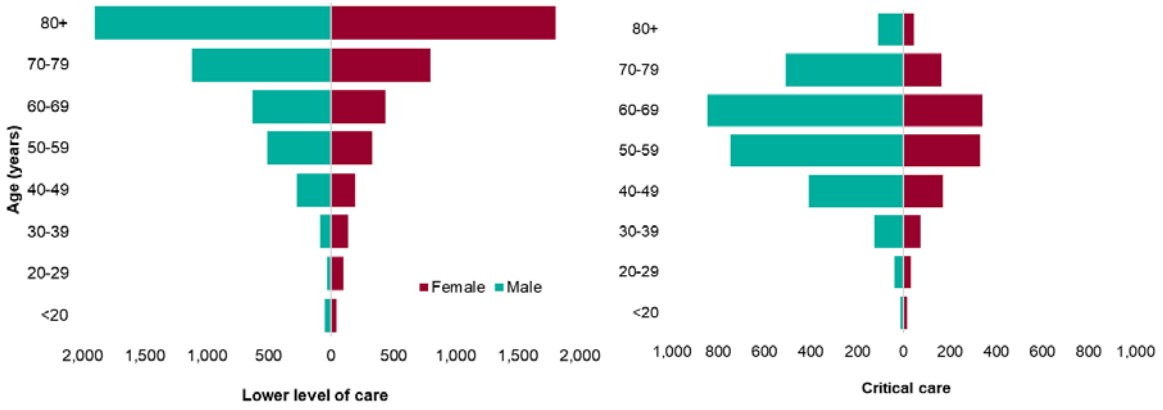



**Figure 1.3.** Age sex pyramids of admissions for laboratory confirmed COVID-19 to acute trusts, for lower level of care and critical care, as of 19 May 2020, England. Source: Public Health England COVID-19 Hospitalisations in England surveillance system (CHESS).

## 1.5 Deaths in confirmed cases

As of 13 May, there had been 17,598 deaths in confirmed cases among males (59.3%) and 12,075 in females (40.7%). 56.3% of deaths were among people 80 years and older. Figure 1.4 shows the distribution of deaths by age groups and sex.

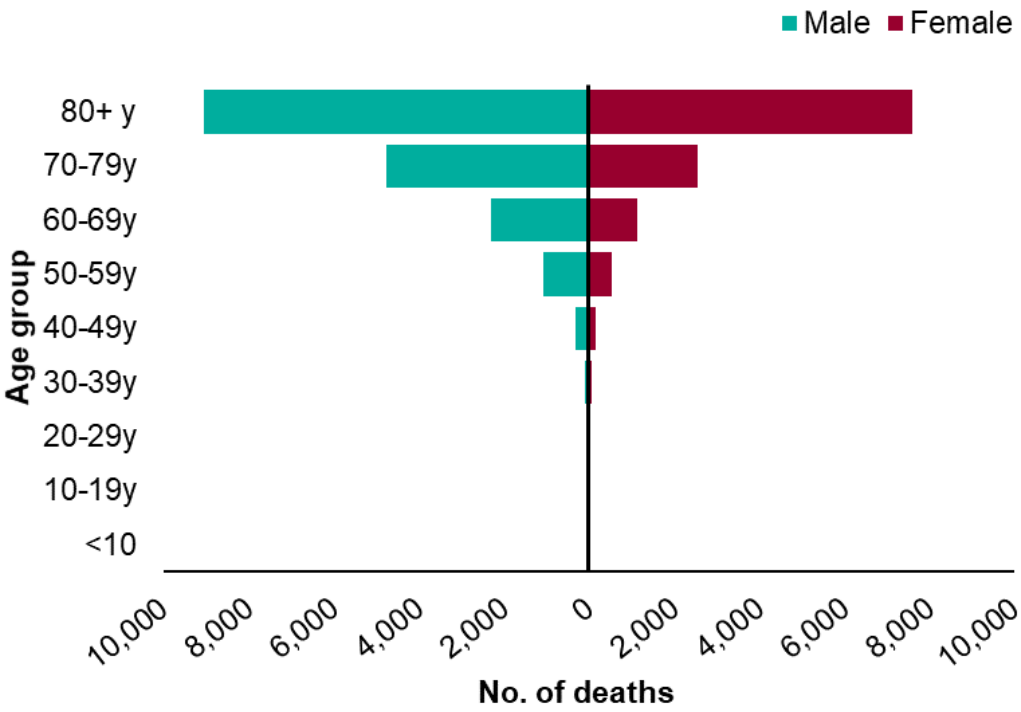



**Figure 1.4**. Age sex pyramid of laboratory confirmed COVID-19 deaths as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

Overall, the mortality rates among confirmed cases per 100,000 population among males were 1.3 to 2.1 higher than among females for all age groups (Figure 1.5). Overall the age standardised mortality rate in males (74.0 per 100,000) was twice that of females (38.0 per 100,000).

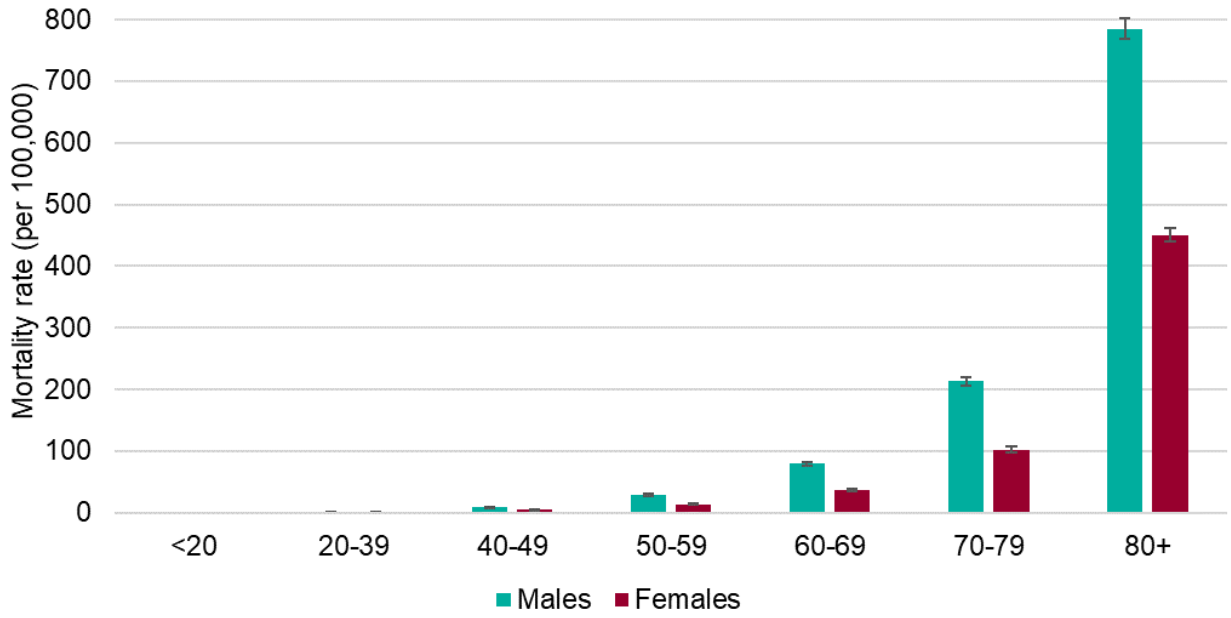



**Figure 1.5.** Crude mortality rates of laboratory confirmed COVID-19 deaths per 100,000 population by age group and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, shows that, compared with people under 40, the probability of death was about three times higher among those aged 40 to 49, nine times higher among those aged 50 to 59, twenty-seven times higher among those aged 60 to 69, fifty times higher among those aged 70 to 79 and seventy times higher among those aged 80 and over. These are the largest disparities by far found in this analysis (Appendix A, table A1).

This analysis also showed that working age males diagnosed with COVID-19 were twice as likely to die than females (Appendix A, table A2). For older adults (65 and over) the disparity remains significant but is much lower, with males in this age group having approximately 50% higher risk of death when compared to females (Appendix A, table A3).

## 1.6 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates from COVID-19 between 21 March and 8 May 2020 with

inequalities in all cause death rates for previous years (the ‘baseline all cause’ figure). COVID-19 deaths in this section include all those where COVID-19 was mentioned on the death certificate. These can include cases where the doctor thought it likely that the person had COVID-19, even when there was no positive test result. The deaths reported by ONS will include deaths that are not included in the ‘deaths in confirmed cases’ because they did not have a positive test result confirmed by a PHE or NHS laboratory, and may not include all ‘deaths in confirmed cases’.

There were 35,425 deaths registered between 21 March and 8 May 2020 that mentioned COVID-19 on the death certificate. This is equivalent to 31% of all deaths over this period.

Males accounted for 57% of deaths from COVID-19 and females 43%, while the baseline all cause figures were 51% and 49%. This indicates that males make up a larger percentage of COVID-19 deaths than all causes.

Among males, 54% of COVID-19 deaths were in those aged 80+ compared with 67% of deaths among females. This compares with 48% and 64% for the baseline all cause deaths respectively. 8% of deaths from COVID-19 among males were in those under 60 years of age compared with 6% of females. This compares with 14% and 9% for baseline all cause deaths respectively.

Figures 1.6A and 1.6B show age specific mortality rates for all causes of death and for deaths mentioning COVID-19 between 21 March 2020 and 8 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018.

Between the ages of 40 to 79, the age specific death rates among males were around double the rates in females, compared with 1.5 times for baseline all causes (Figure 1.6A and 1.6B).

Age specific death rates from COVID-19 increase with age and were highest in those aged 80+ where they were 4.0 times higher than in those aged 70 to 79 in males and 5.1 times higher in females. This ratio is slightly higher than the baseline all cause data for 2014 to 2018 (3.7 and 4.8 in males and females respectively) (Figure 1.6A and 1.6B). Deaths from COVID-19 have a slightly older age distribution than baseline all cause deaths, particularly for males.

The age and sex distribution of ONS deaths from COVID-19 and deaths in confirmed cases were also broadly similar, but ONS deaths had a slightly higher proportion in older ages.

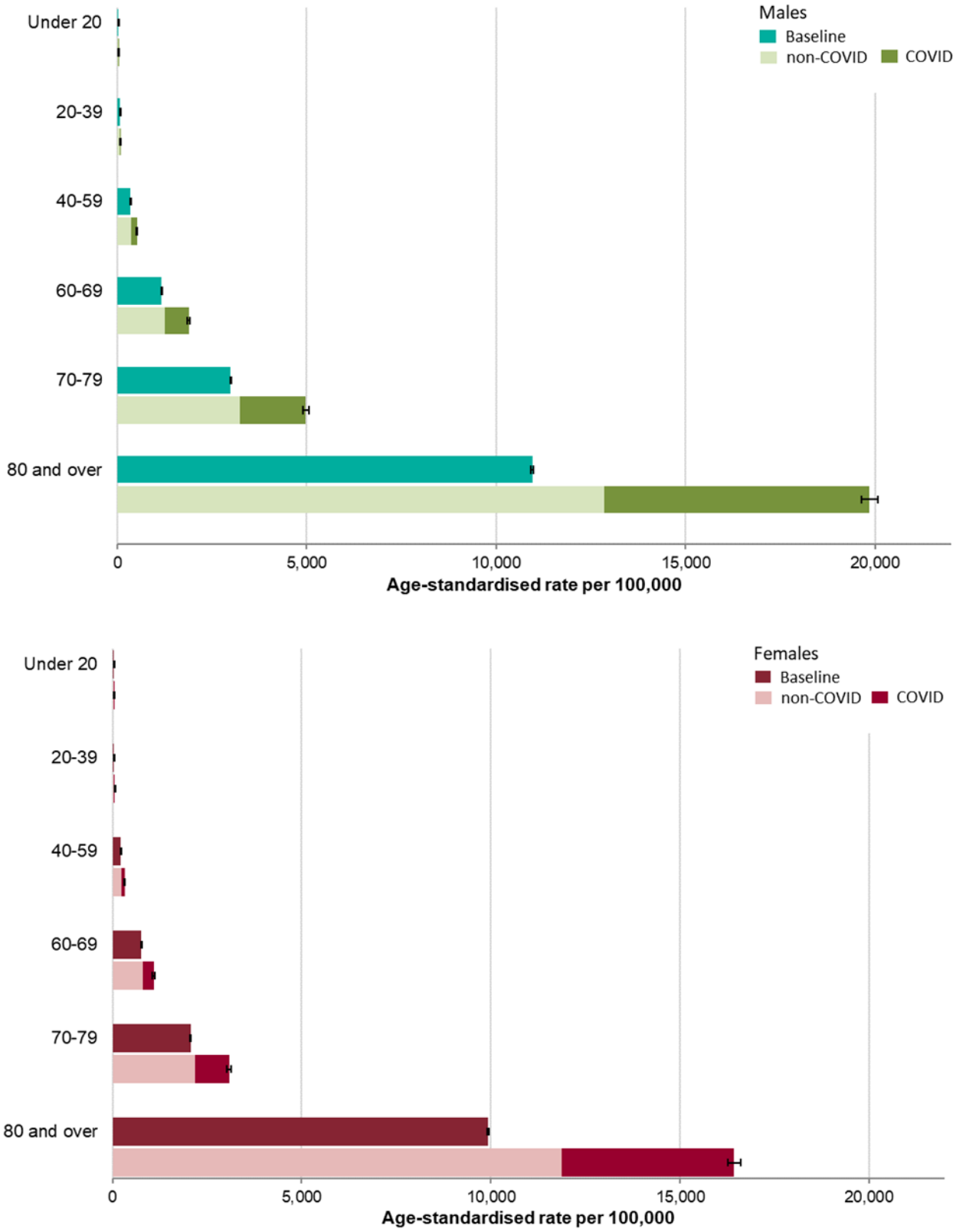



**Figure 1.6A and 1.6B.** Age specific death rates for all cause deaths and deaths mentioning COVID-19, compared with baseline, by sex, 21 March to 8 May 2020, England. Source: Public Health England analysis of ONS death registration data

## 1.7 Excess mortality

PHE has developed a model to estimate all cause excess mortality in the population. Figure 1.7 shows the number of excess deaths by age and sex in the period 20 March to 7 May against the number of deaths that would be expected for corresponding dates in 2015 to 2019. It also illustrates how many deaths have COVID-19 mentioned on the death certificate.

The model suggests there have been 46,056 excess deaths between 20 March 2020 and 7 May 2020, 24,731 in males and 21,324 in females. This is similar to the number of excess deaths reported by ONS for England and Wales up until 8 May 2020 (7). ONS compared deaths in 2020 with the simple average for the years 2015 to 2019. However, this will not adjust for ageing of the population or the effect of Easter or bank holidays on the number of deaths registered. The PHE model does adjust for this. More details are provided in the data sources and methodologies section.

The majority of excess deaths have occurred in those aged 75 and over, with 20,841 (45%) in those aged 85+ and 13,921 (30%) in those aged 75 to 84.

There have been fewer deaths than expected in children under 15 years of age. Accidents are a leading cause of death in children and these may have reduced over this period, following social distancing measures, or there could be a delay in the registration of these deaths. Among those age groups where there were excess deaths, the number of deaths with COVID-19 mentioned on the death certificate is equivalent to more than 80% of all excess deaths in each age group, except those aged 85+ where this proportion is lower.

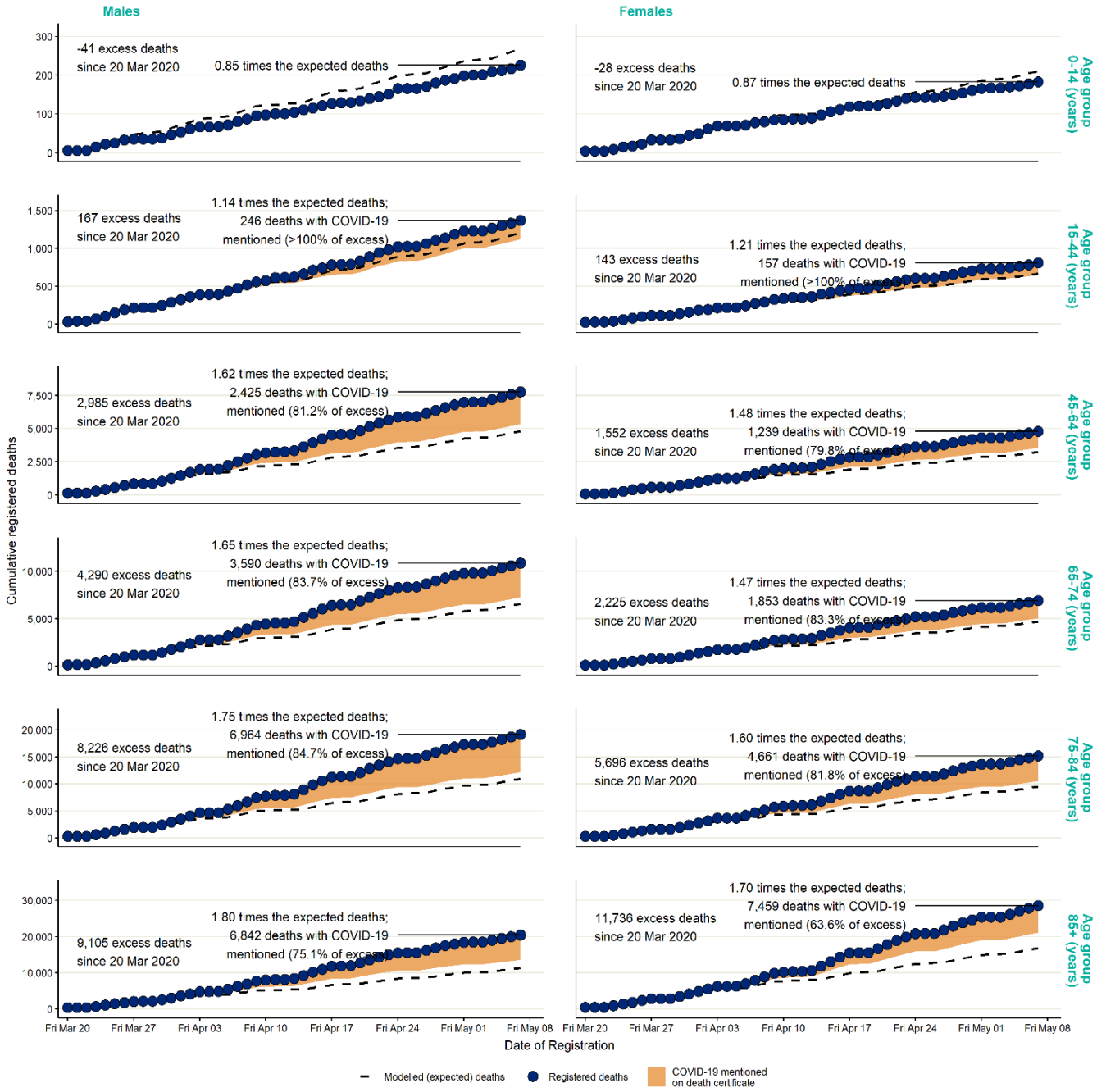



**Figure 1.7.** Cumulative all cause deaths by date of registration by age and sex, 20 March to 7 May 2020, England. Source: Public Health England excess mortality model based on ONS death registration data.

# 2. Geography

## 2.1 Main messages

At 13 May 2020, the regional pattern in diagnoses rates and death rates in confirmed cases among males were similar. London had the highest rates followed by the North West, the North East and the West Midlands. The South West had the lowest.

For females the North East and the North West had higher diagnosis rates than London while London had the highest death rate in confirmed cases.

Diagnosis rates by local authority were highly clustered. Authorities, which are mostly urban, in London, the North West, the West Midlands and the North East had the highest rates. A similar geographic pattern is seen for death rates.

The peak in the number of diagnosed cases happened first in London, the East Midlands and the West Midlands in week ending 4 April. Diagnosed cases peaked latest in South East and Yorkshire and Humber in week ending 18 April. The number of deaths in confirmed cases peaked in week ending 11 April in all regions except North West and Yorkshire and Humber, where it peaked in week ending 18 April.

Death rates in London from COVID-19 were more than three times higher than in the region with the lowest rates, the South West. This level of inequality between regions is much greater than the inequality between all cause mortality rates in previous years.

The excess mortality model suggests there have been 9,035 excess deaths in London between 20 March and 7 May, compared with 2,900 in the South West.

## 2.2 Background

The burden of disease and mortality from COVID-19 is not evenly spread in the population. The UK coronavirus dashboard (8) presents data on the number of cases and deaths in people who have tested positive for SARS-CoV-2 and shows considerable variation in the number of cases by region across the UK. As at 21 May 2020, the number of cases was highest in London and lowest in the South West. The PHE weekly COVID-19 surveillance report as at 13 May 2020 shows the North East and North West regions to have the highest diagnosis rates per 100,000 population, however, London had the highest crude mortality rate in confirmed cases (6).

ONS analysis shows that between 1 March and 17 April 2020, local authorities in London had the highest mortality rates from COVID-19 in England when the age structure of the population was taken into account (9).

Findings from other studies have demonstrated that people living in urban areas versus rural areas have increased odds of testing positive for COVID-19 (10). At the local authority level in England, population density, deprivation and other factors associated with urban areas such as an ethnically diverse population may also be associated with higher mortality from COVID-19 (11).

## 2.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

Data reported to PHE up to 13 May 2020 shows that London had the highest number of diagnosed cases (26,024) and the South West the lowest (7,155) and that there was considerable variation among local authorities in England (Table 2a in the data pack).

The highest weekly number of diagnosed cases was reported in week ending 4 April in the East Midlands, London and West Midlands; in week ending 11 April in the East of England, North East, North West and South West; and in week ending 18 April in the South East and Yorkshire and Humber (Figure 2.1).

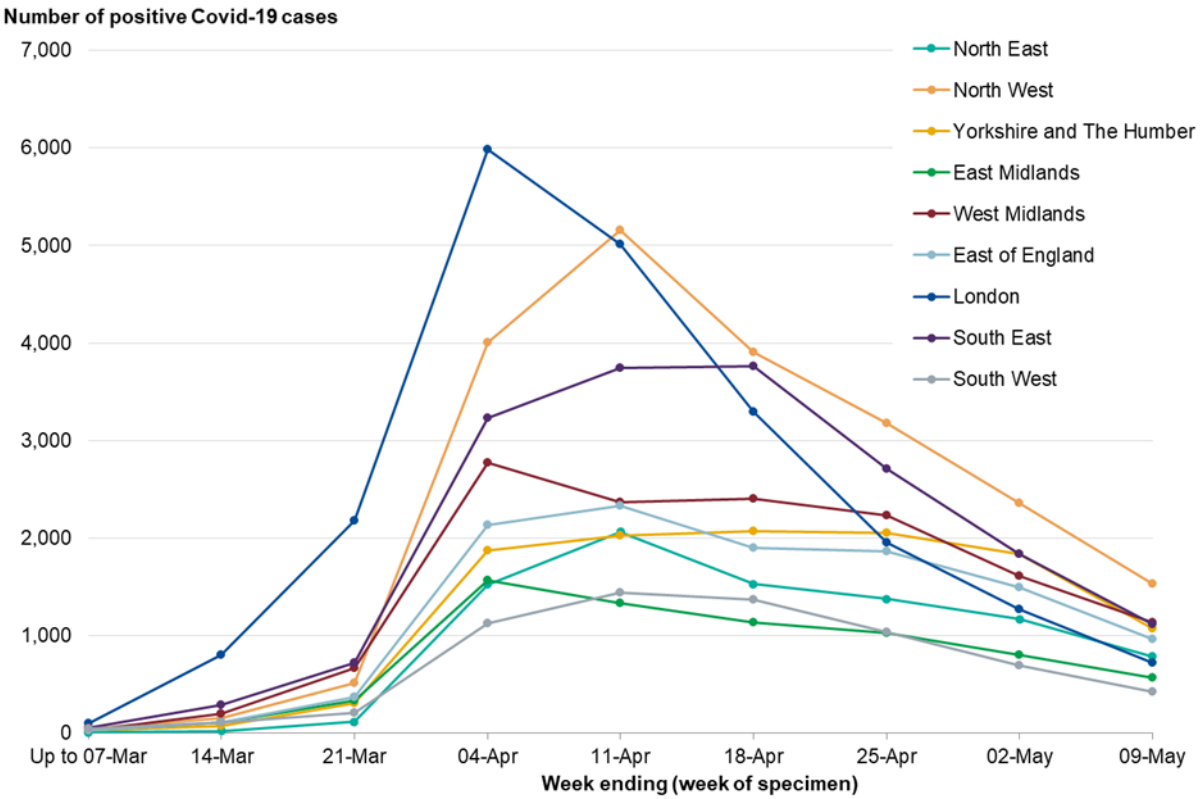



**Figure 2.1.** Number of positive cases by week by region, as of 9 May 2020, England. Source: Public Health England Second Generation Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The age standardised diagnosis rates (which are adjusted for the population size of the areas and to account for the difference in their age structure) were highest in London (423.9 per 100,000 population) followed by the North West (307.7) and the North East (294.7) for males. For females the rate was highest in the North East (405.0) followed by the North West (335.3) and London (318.5) (Figure 2.2). The South West region had the lowest standardised diagnosis rate for both males and females.

In the North East, North West, Yorkshire and the Humber, and the South East the female diagnosis rates were higher than males, whereas in the East Midlands, East of England and London the opposite was true. In England as a whole the rates were broadly similar for males and females.

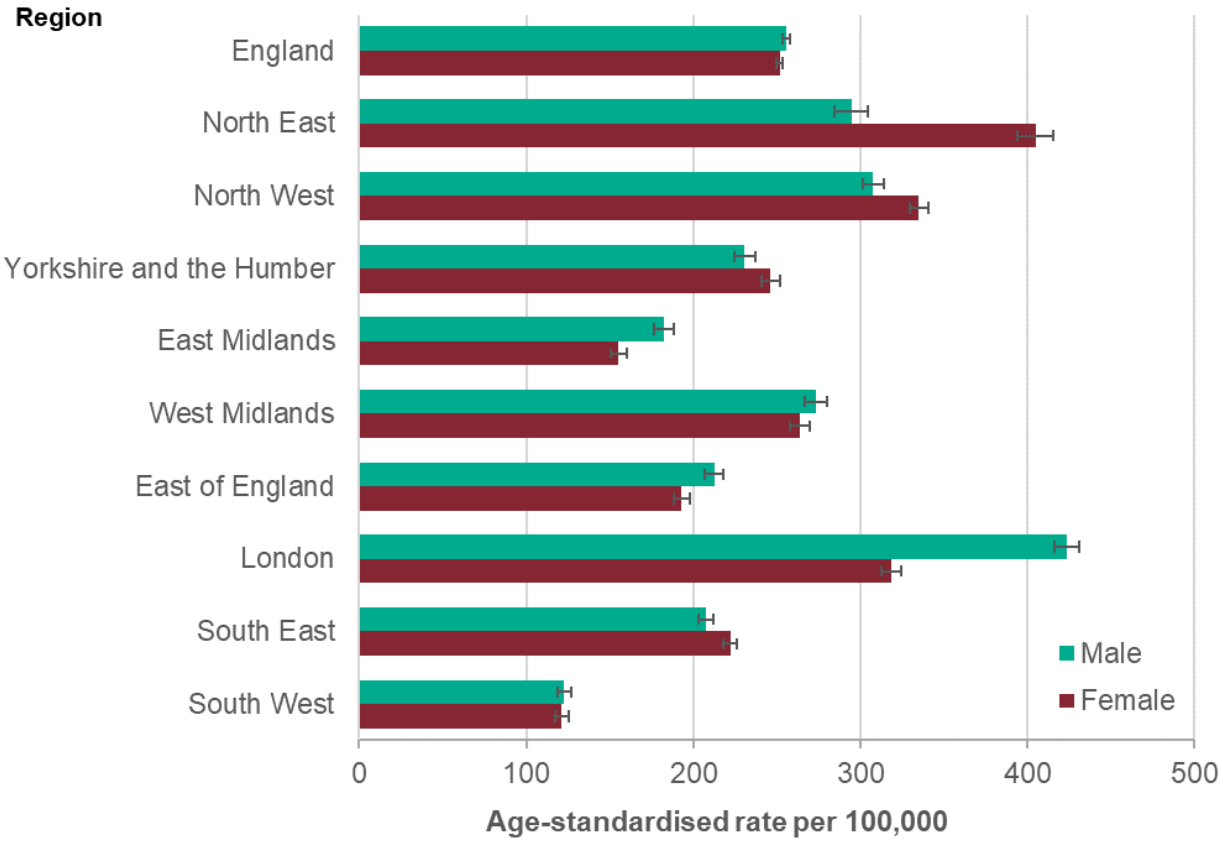
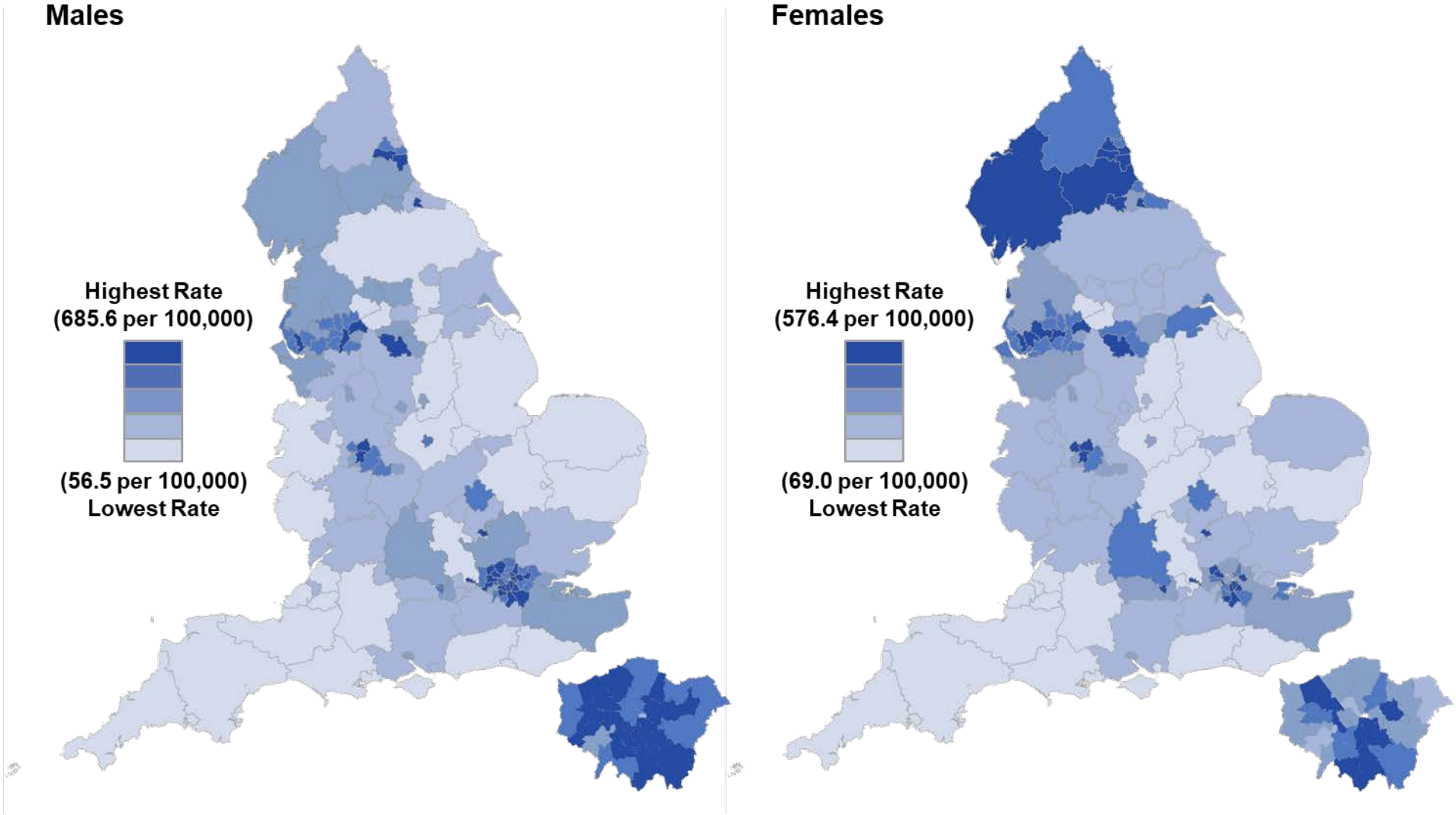



**Figure 2.2.** Age standardised diagnosis rates by region and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

Maps 2.1A and 2.1B show age standardised diagnosis rates by upper-tier local authority in England. Among males there is a 12-fold difference in the rates between local authorities and an eight-fold difference in the rates among females. Variation in diagnosis rates will be partly influenced by variation in testing practices between areas.

The maps show diagnosis rates are highly clustered. Authorities which are mostly urban areas, in London, the North West, the West Midlands and the North East had the highest rates. For males, the ten local authorities with the highest diagnosis rates are in London. For females, Cumbria has the sixth highest rate which is a predominately rural area in the North West. These data are also presented in the data pack in Table 2a.




**Map 2.1A and 2.1B.** Age standardised diagnosis rates by local authority and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

## 2.4 Hospitalisations

This section presents data reported to the COVID-19 Hospitalisations in England surveillance system (CHESS). Reporting varies by trusts and the majority of trusts in London do not consistently report to CHESS which will impact on the representativeness of the hospitalised cases. Therefore, rather than providing number of hospitalised patients, daily rates are reported in this section and are analysed using the reporting trusts' catchment area population (rather than regional population denominator) to account for this issue.

Figure 2.3 shows the three day moving average rate of hospital admissions to all levels of care (critical and lower level of care) for laboratory confirmed COVID-19 between 15 March and 19 May 2020 by NHS region. The highest rate of hospital admissions occurred between 3 and 9 of April for all regions.

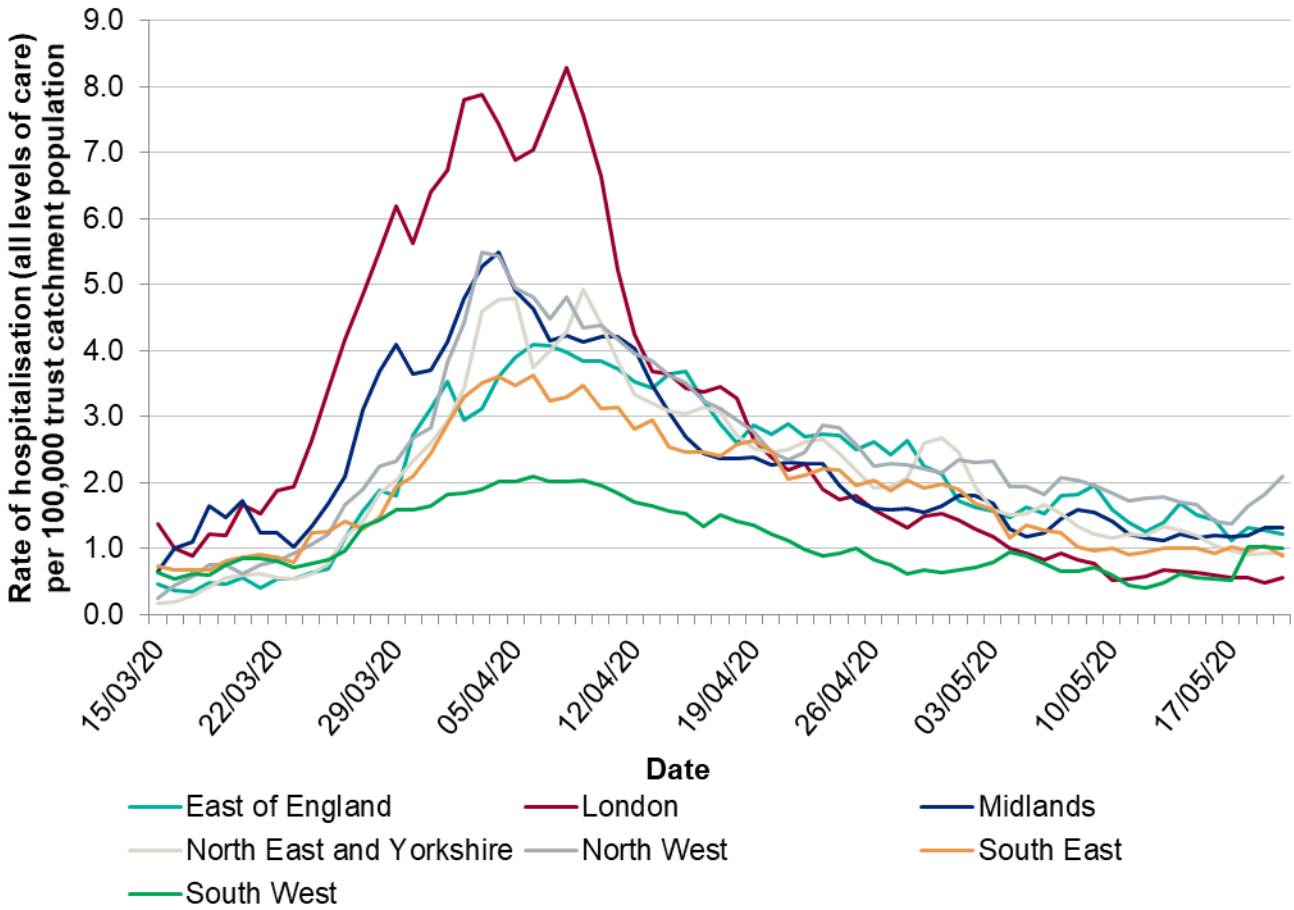



**Figure 2.3.** 3-day moving average rate of hospital admission to all levels of care for laboratory confirmed COVID-19, by NHS region, as of 19 May 2020, England. Source: Public Health England COVID-19 Hospitalisations in England surveillance system (CHESS).

## 2.5 Deaths in confirmed cases

The trend in the number of deaths in confirmed cases by week in each region shows that London had the highest number of deaths every week up until week ending 18 April after which the North West had the highest number of deaths. The highest weekly number of deaths in confirmed cases was reported in week ending 11 April in all regions except the North West and Yorkshire and Humber, where it was reported in week ending 18 April (Figure 2.4).

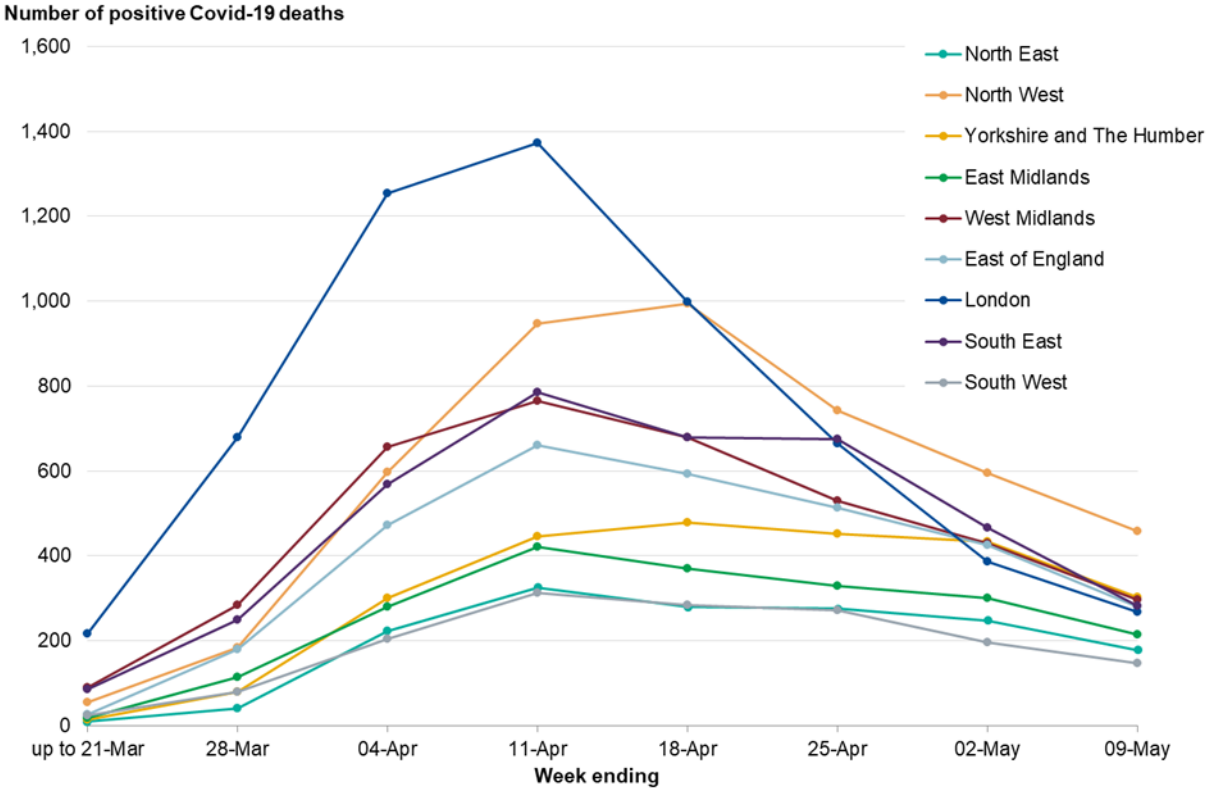



**Figure 2.4.** Number of deaths in laboratory confirmed COVID-19 cases by region and week, as of 9 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System. Note: The last week of data was removed as it was an incomplete week.

Up to 13 May 2020, the age standardised death rate among confirmed cases, per 100,000 population, was highest in London for both males (140.3) and females (66.8) (Figure 2.5) and were also high in the North East, North West and West Midlands. The South West had the lowest standardised death rate among confirmed cases for both males and females. In all regions the death rate in males was higher than females.

Among males, the regional pattern in diagnoses rates and death rates in confirmed cases were similar. However, for females the North East and the North West had the highest diagnosis rates while London had the highest death rate in confirmed cases. This may be explained by different testing strategies and capacity at different times of the pandemic.

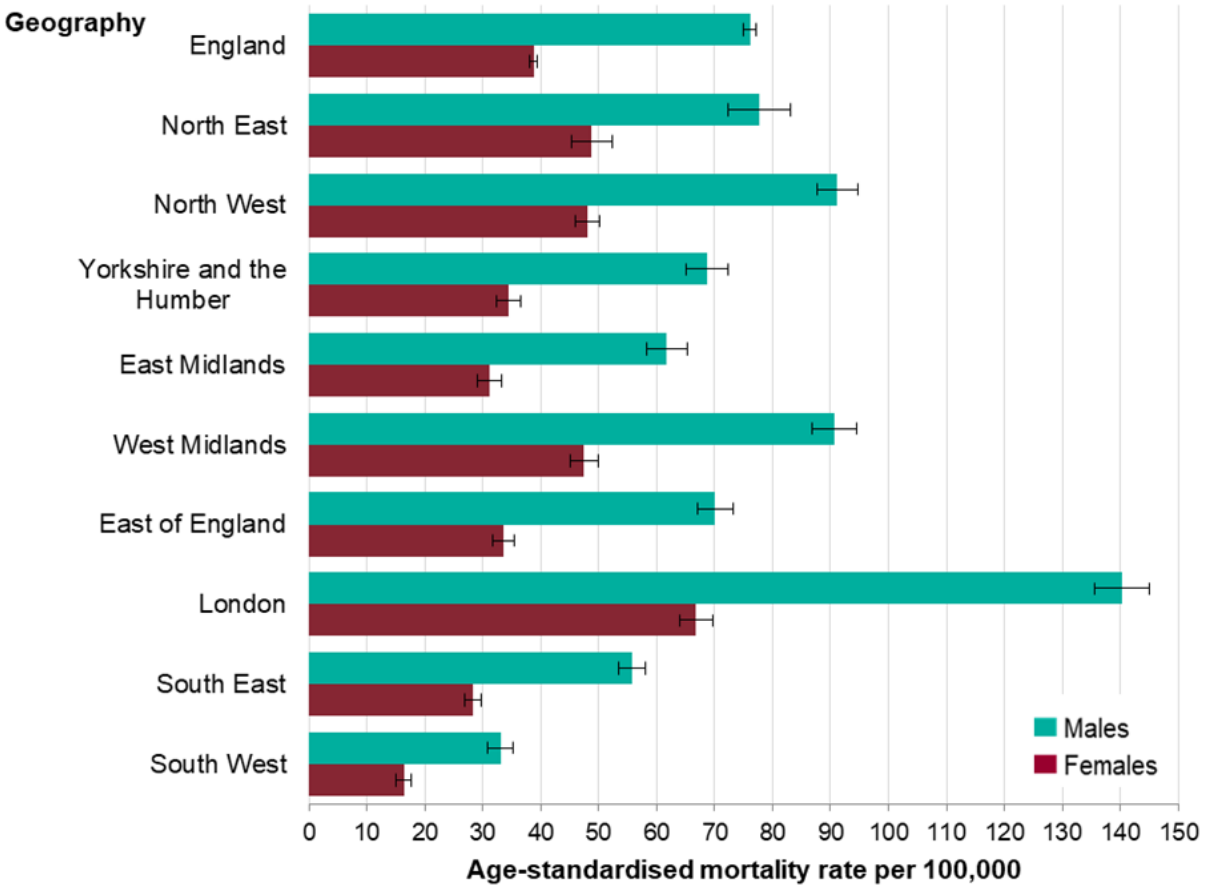
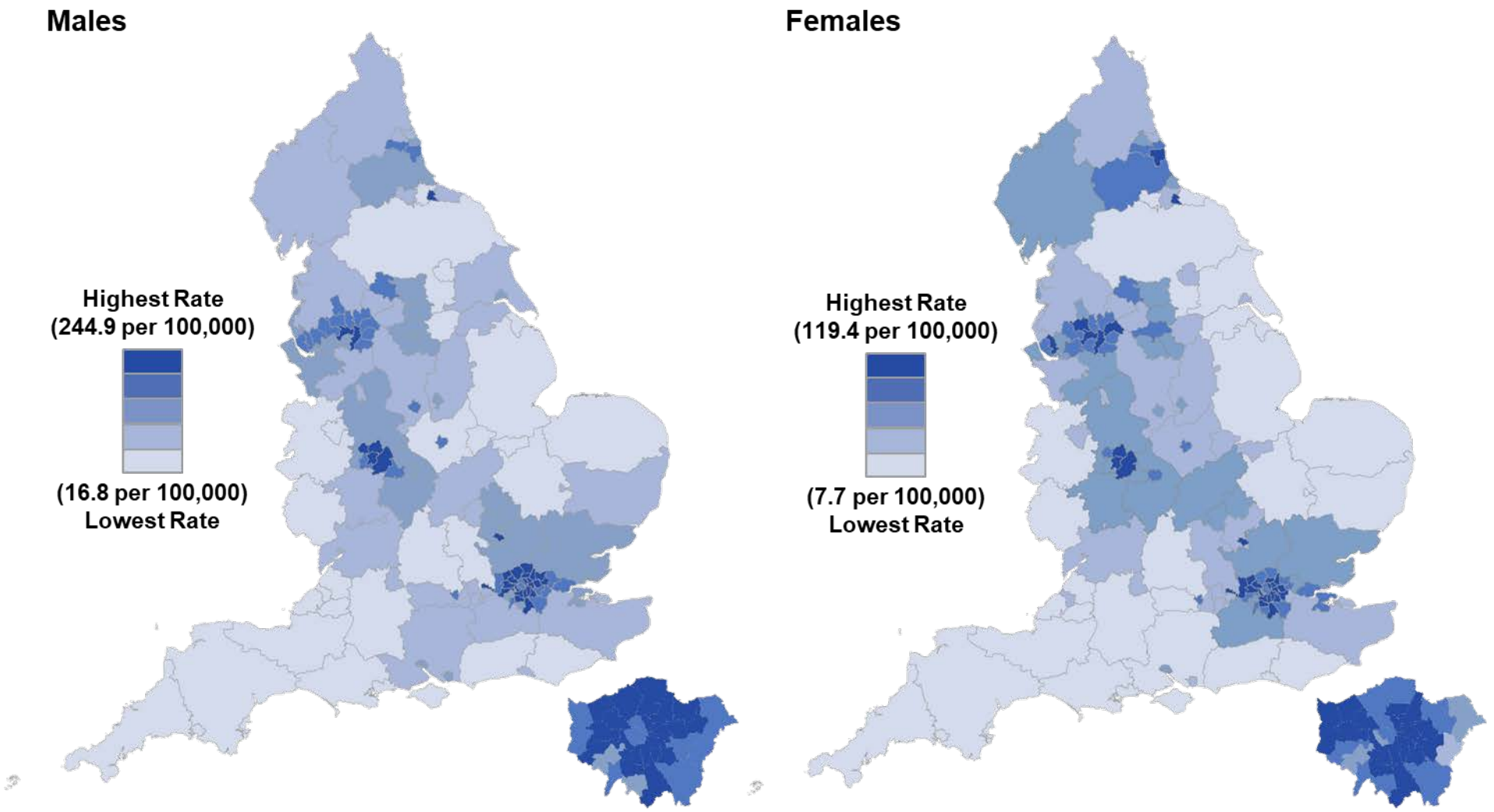



**Figure 2.5.** Age standardised death rates in laboratory confirmed COVID-19 cases, per 100,000 population, by region and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

Maps 2.2A and 2.2B show age standardised death rates among confirmed cases, per 100,000 population, by upper-tier local authority in England. The maps show that death rates were highly clustered. Authorities, which are largely urban areas, in London, the North West, the West Midlands and the North East had the highest death rates. For males, the eight authorities with the highest death rates among confirmed cases are in London. (Table 2b in the data pack).

An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, showed that among people of working age (aged 20 to 64) those living outside of London had a slightly lower risk of death, except for East Midlands and the East of England where the risk was similar. In older ages (65 and over) people living in the North East had a slightly lower risk of death while those in the East of England a higher risk of death compared with London. (Appendix A, tables A2 and A3). However, the magnitude of these inequalities was not as great as that seen for population based death rates for confirmed cases.

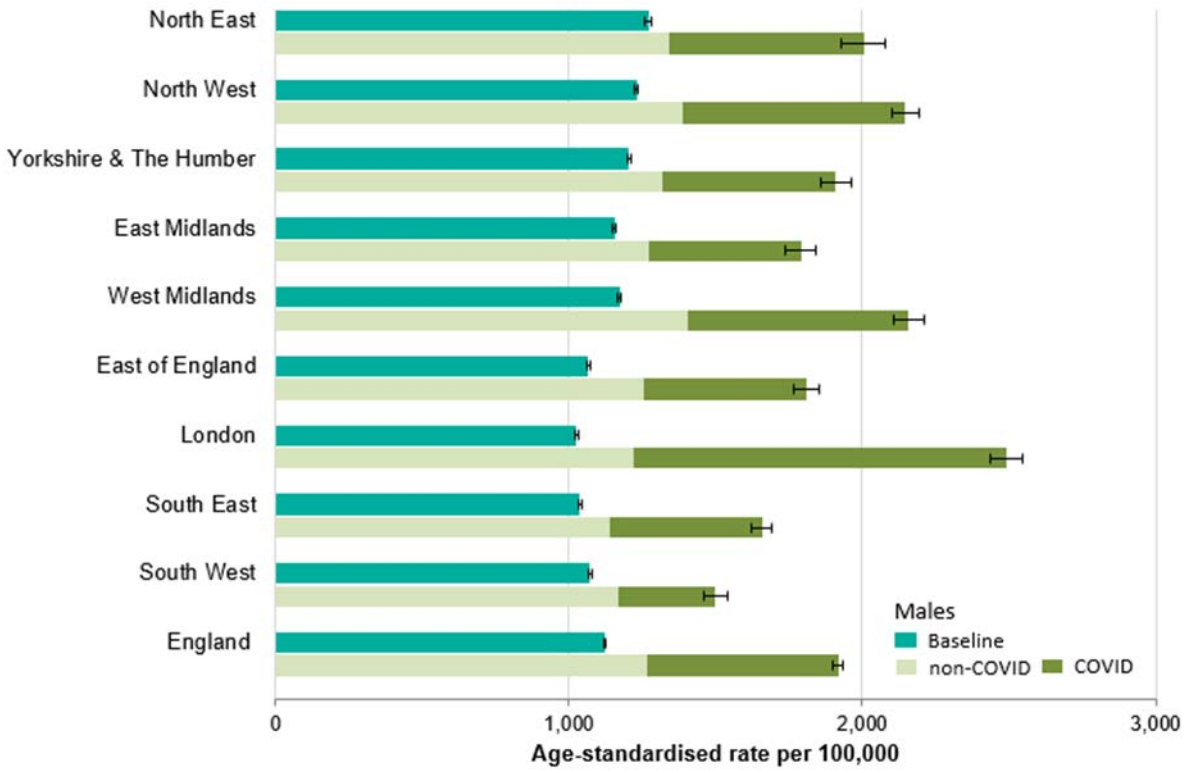



**Map 2.2A and 2.2B.** Age standardised death rates in laboratory confirmed COVID-19 cases, per 100,000 population, by local authority and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

## 2.6 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates from COVID-19 between 21 March and 8 May 2020 with inequalities in all cause death rates for previous years (the 'baseline all cause' figure).

Figures 2.6A and 2.6B show age standardised mortality rates for all causes of death and for deaths mentioning COVID-19 by region between 21 March 2020 and 8 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018. The same information is presented by local authority in Table 2c in the data pack.



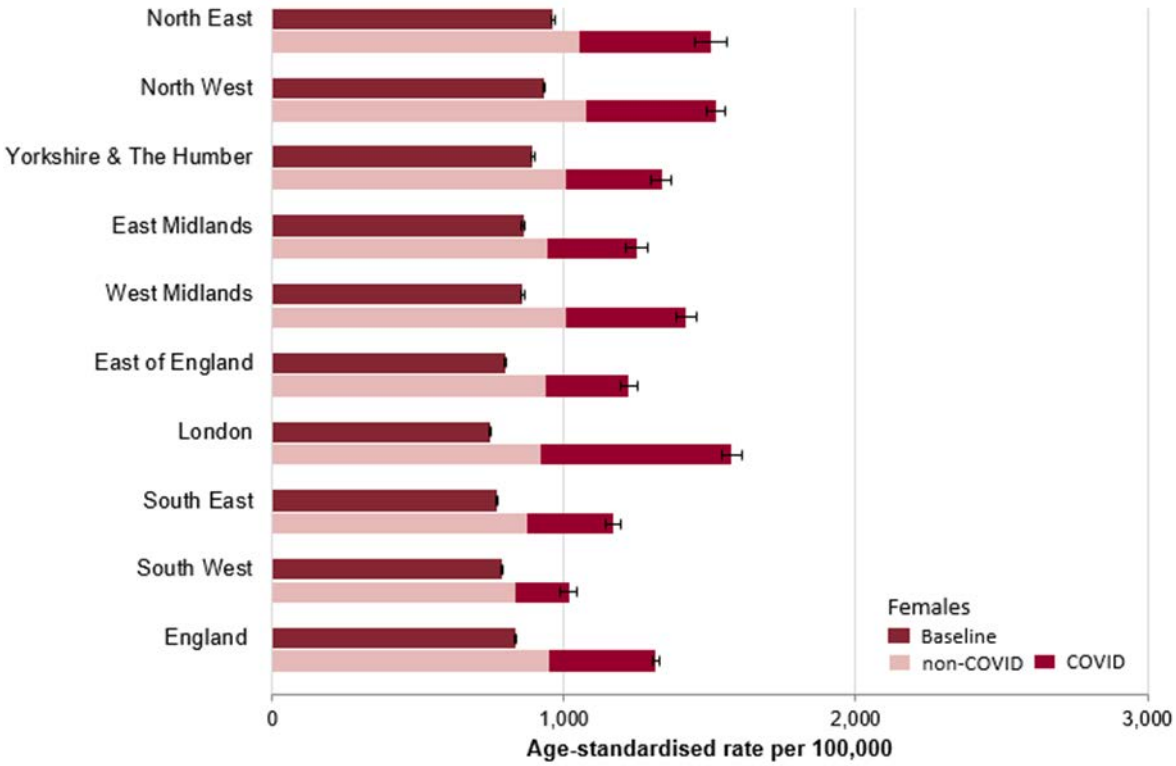



**Figure 2.6A and 2.6B.** Age standardised mortality rates for all cause deaths and deaths mentioning COVID-19, 21 March to 8 May 2020, compared with baseline mortality rates (2014 to 2018), by region and sex, England. Source: PHE analysis of ONS death registration data

The age standardised death rates from COVID-19 were highest in London for both males and females but were lowest in the South West (Figure 2.6A and 2.6B). This is consistent with the pattern seen for deaths in confirmed cases. The ratio of these rates for males was 3.8 and for females 3.5, indicating that mortality in London from COVID-19 was more than three times higher than the South West.

The baseline all cause mortality rates were highest in the North East and were 1.2 times higher in males and 1.3 times higher in females than London, the region with the lowest rates. Therefore, regional inequalities in COVID-19 mortality are greater than those seen previously for all cause mortality and the geographic gradient is different. London had the highest COVID-19 mortality rates, but the lowest baseline all cause mortality rates.

## 2.7 Excess mortality

PHE has developed a model to estimate all cause excess mortality in the population. Table 2.1 shows results from the excess mortality model and includes the number of excess deaths by sex and region in the period 20 March to 7 May against the number of

deaths that would be expected for corresponding dates in 2015 to 2019. It also highlights how many deaths have COVID-19 mentioned on the death certificate.

Overall the model suggests deaths in London have been 2.3 times higher than expected in this period, compared with 1.4 times higher in the South West.

**Table 2.1.** Cumulative all cause deaths by date of registration and region, 20 March to 7 May 2020 England. Source: Public Health England excess mortality model based on ONS death registration data

| | Observed deaths | Expected deaths | Ratio observed/ expected | Excess deaths | COVID-19 deaths | COVID-19 deaths as % excess |
|---|---|---|---|---|---|---|
| North East | 6196 | 3932 | 1.6 | 2264 | 1906 | 84.2% |
| North West | 17133 | 10050 | 1.7 | 7083 | 5460 | 77.1% |
| Yorkshire and The Humber | 11346 | 7321 | 1.5 | 4025 | 3086 | 76.7% |
| East Midlands | 9659 | 6394 | 1.5 | 3265 | 2531 | 77.5% |
| West Midlands | 13548 | 7731 | 1.8 | 5817 | 4293 | 73.8% |
| East of England | 13170 | 8133 | 1.6 | 5037 | 3513 | 69.7% |
| London | 16073 | 7038 | 2.3 | 9035 | 7383 | 81.7% |
| South East | 18205 | 11575 | 1.6 | 6630 | 5079 | 76.6% |
| South West | 10939 | 8039 | 1.4 | 2900 | 2188 | 75.4% |
| Total | 116269 | 70213 | 1.7 | 46056 | 35439 | 76.9% |

# 3. Deprivation

## 3.1 Main messages

The trend in the number of diagnosed cases by deprivation quintile shows that cases in the least deprived group peaked earlier and lower than other groups and at 13 May, the cumulative number of cases and diagnosis rate was highest in the most deprived quintile.

The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females. This is greater than the ratio for all cause mortality between 2014 to 2018 indicating greater inequality in death rates from COVID-19 than all causes.

Survival among confirmed cases, after adjusting for sex, age group, ethnicity and region was lower in the most deprived areas, particularly among those of working age where the risk of death was almost double the least deprived areas.

In summary, people in deprived areas are more likely to be diagnosed and to have poor outcomes following diagnosis than those in less deprived areas. High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes remain after adjusting for ethnicity, but the role of underlying health conditions requires further investigation.

## 3.2 Background

Evidence from previous analysis suggests that there is some association between area based deprivation levels and incidence and mortality from COVID-19. However, this may be weaker once other factors such as ethnicity are taken into consideration (11) (12).

Deprivation is classified using the Index of Multiple Deprivation and encompasses a wide range of aspects of an individual’s living conditions including income, employment, education, health, crime, housing and the living environment (13). Deprived areas can be found in both urban and rural areas of England.

ONS analysis shows that between 1 March and 17 April 2020 the deprived areas in England had more than double the mortality rate from COVID-19 than the least deprived areas (9). Other sources have shown that people living in more deprived areas were more likely to test positive for COVID-19 (10) and to have higher mortality rates (14).

The latest report from the Intensive Care National Audit and Research Centre (ICNARC) used data up to 21 May 2020 and showed that a larger proportion of patients critically ill in intensive care units (ICU) with COVID-19 were from the most deprived quintile of areas (25.0%) than the least deprived (14.7%), however, this pattern was similar to the pattern seen previously among patients admitted for viral pneumonia between 2017 and 2019 (2). Patient outcomes from COVID-19 across deprivation categories were similar.

## 3.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

The trend in the number of diagnosed cases by deprivation quintile shows that cases in the least deprived group (quintile 5) peaked earlier and lower than other groups (Figure 3.1). As of 13 May the cumulative number of cases was highest in the most deprived quintile (quintile 1). Deprivation quintiles are roughly equal in population size and are defined in section 10.

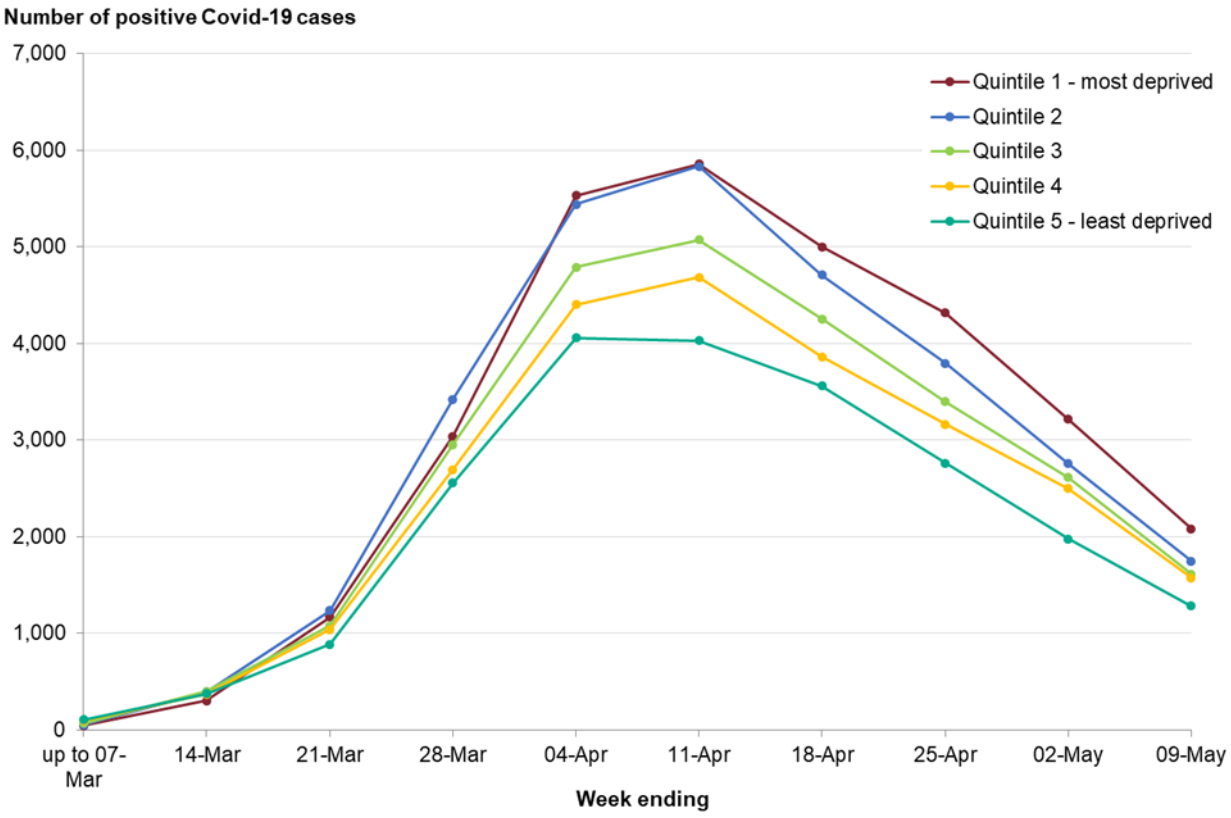


**Figure 3.1.** Number of positive confirmed cases by deprivation quintile and week, as of 9 May 2020, England. Source: Public Health England Second Generation Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The age standardised diagnosis rates were highest in the most deprived quintile in both males and females, and lowest in the least deprived quintile. The rate in the most deprived quintile was 1.9 times the rate in the least deprived quintile among males and 1.7 times among females. In quintiles 1 and 2 (the most deprived) the male diagnosis rates were significantly higher than females, whereas in all other quintiles the rates in the sexes were very similar (Figure 3.2).

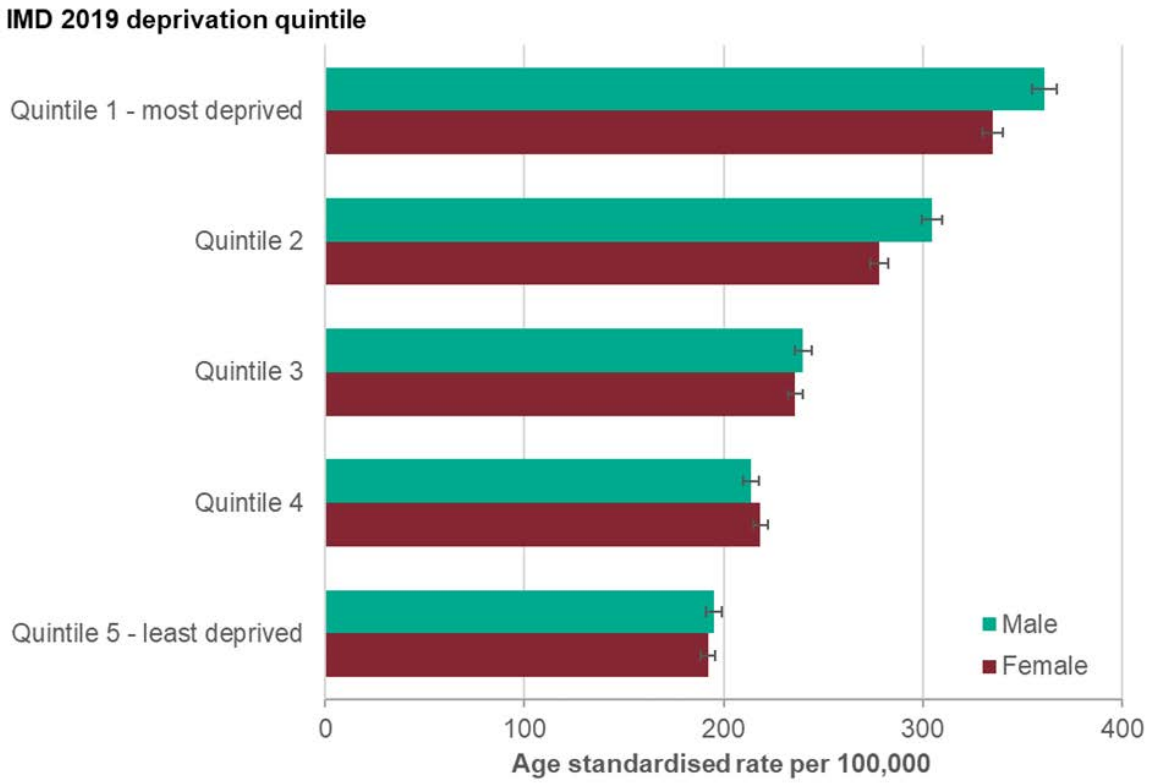



**Figure 3.2.** Age standardised diagnosis rates by deprivation quintile and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

## 3.4 Deaths in confirmed cases

The trend in the number of deaths in confirmed cases by week in each quintile shows that by week ending 11 April the number of weekly deaths was highest in the most deprived quintile (quintile 1) and remained so for every following week. For all quintiles, the week with the peak number of deaths in confirmed cases was week ending 11 April 2020 (Figure 3.3). By 13 May the cumulative number of deaths was highest in the most deprived quintile (quintile 1) (6,894) and lowest in the least deprived (quintile 5) (4,672).

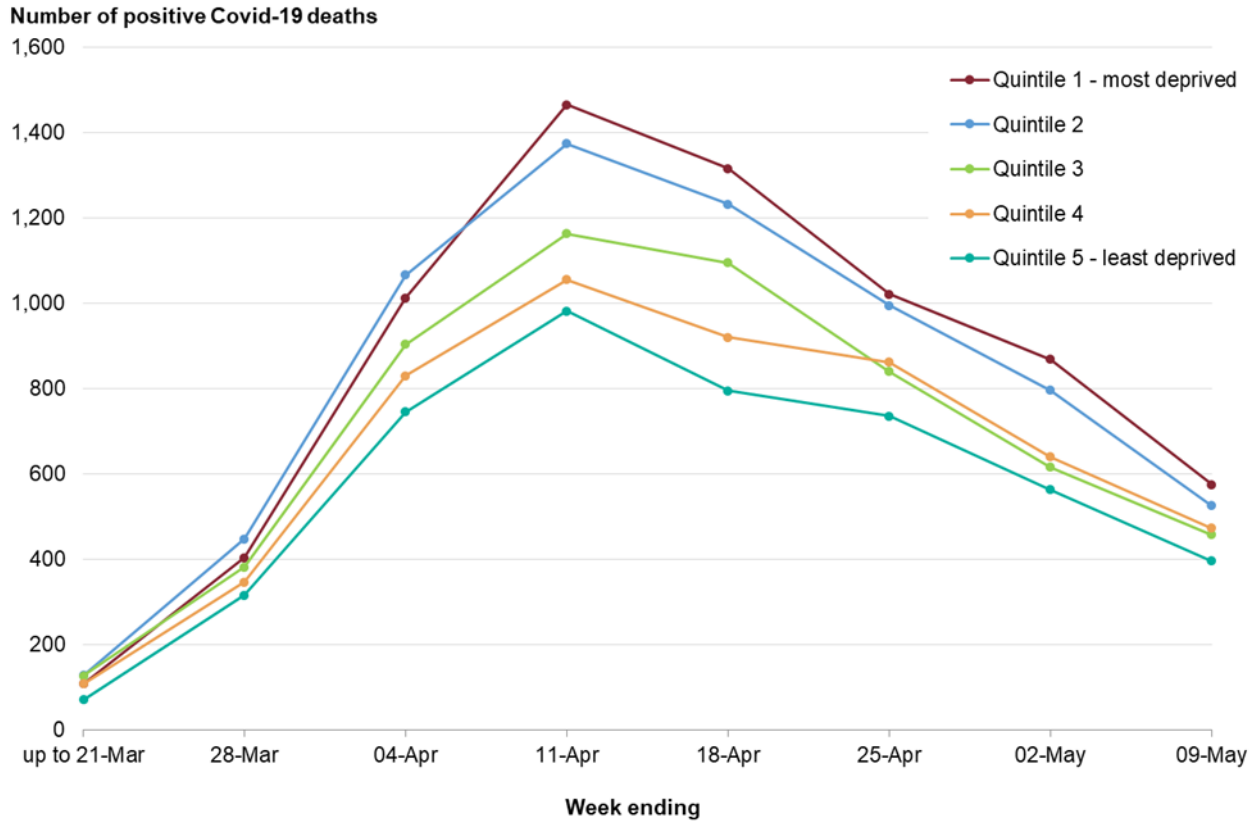



**Figure 3.3.** Number of deaths in laboratory confirmed COVID-19 cases by deprivation quintile and week, as of 9 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The age standardised death rates in confirmed cases, per 100,000 population, were highest in the most deprived quintile in both males and females, and lowest in the least deprived quintile. The rate in the most deprived quintile was 2.3 times the rate in the least deprived quintile among males and 2.4 times among females. In all quintiles the male death rates were significantly higher than females (Figure 3.4).

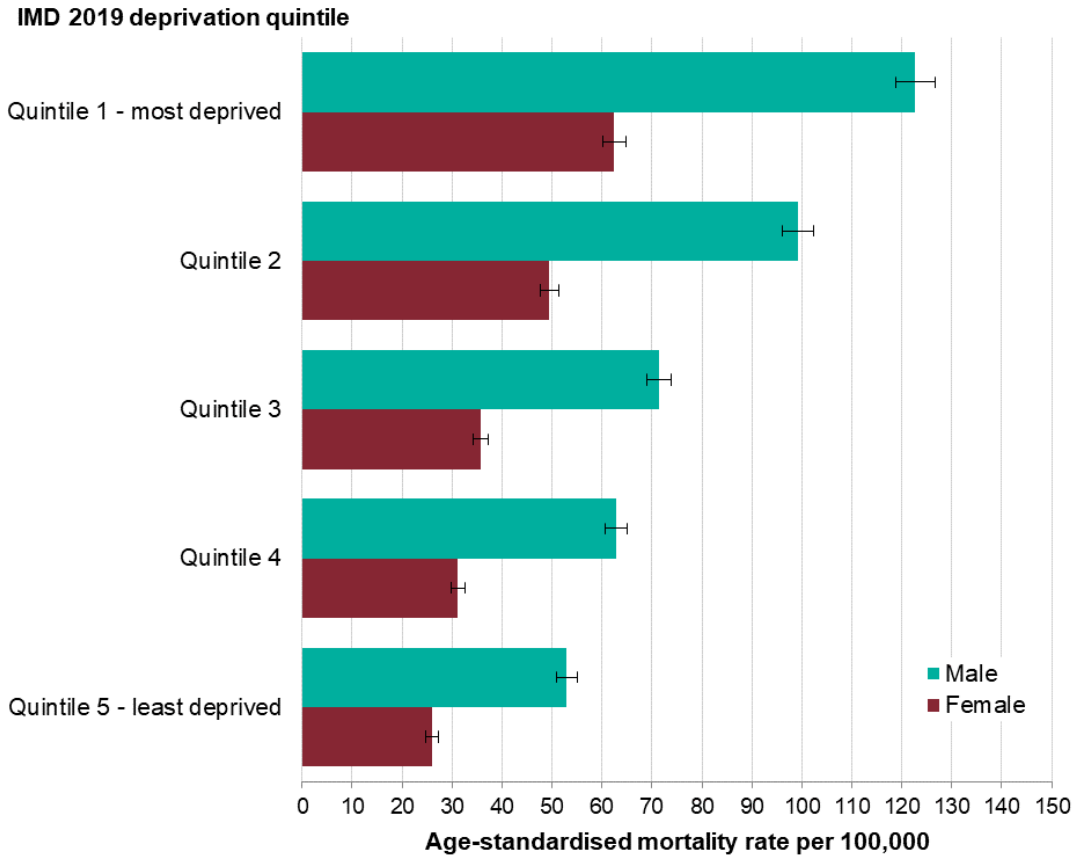



**Figure 3.4.** Age standardised death rates in laboratory confirmed COVID-19 cases by deprivation quintile and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, showed that, among people of working age (20 to 64), people living in the most deprived areas of the country were almost twice as likely to die than those living in the least deprived (Appendix A, table A2). For older adults (65 and over) the disparity remains significant but is much lower, with people in the most deprived areas having approximately 9% higher risk of death when compared to people in the least deprived areas (Appendix A, table A3).

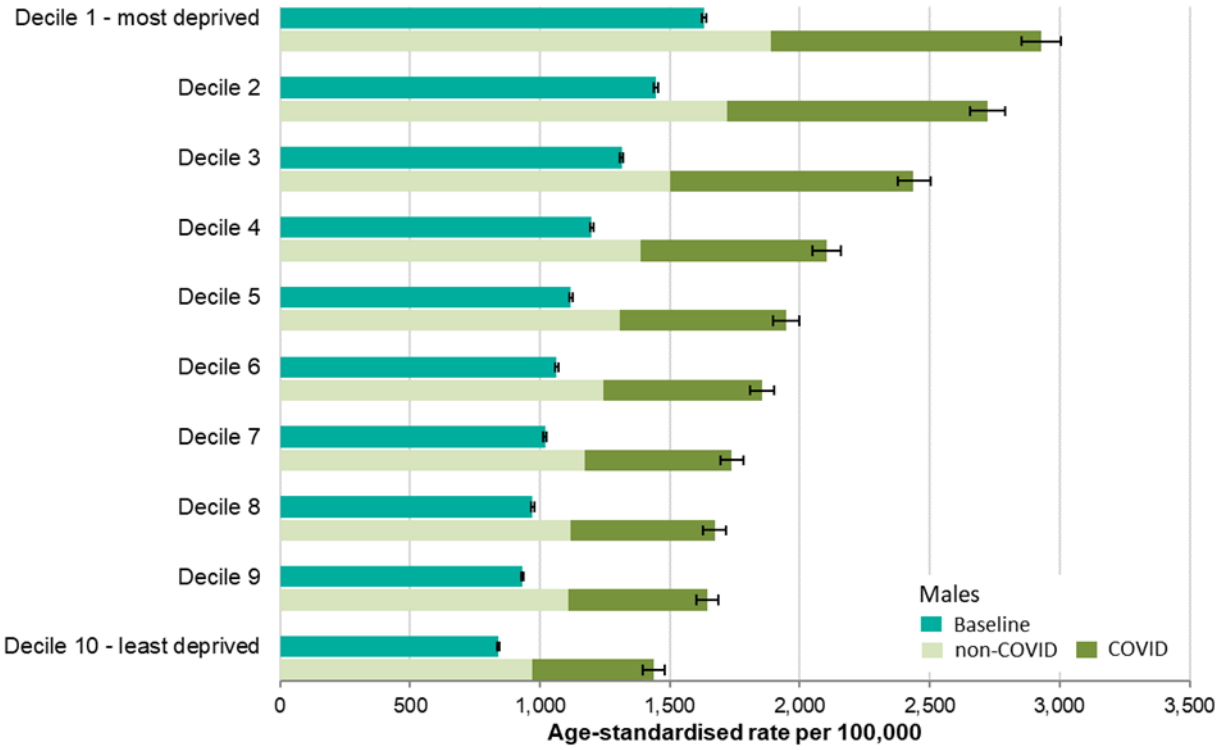
## 3.5 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates mentioning COVID-19 on the death certificate with inequalities in all cause death rates for previous years (the ‘baseline all cause’ figure).

Figure 3.5A and 3.5B show age standardised mortality rates for all causes of death and for deaths mentioning COVID-19 by deprivation decile between 21 March 2020 and 8 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018.

The age standardised death rate from COVID-19 was highest in the most deprived decile in males, but in the second most deprived decile in females (Figure 3.5A and 3.5B). The rate in the most deprived decile was 2.2 times the rate in the least deprived decile among males and females. In all deciles the male death rates were significantly higher than females. This analysis is consistent with the analysis by ONS (9).

From 2014 to 2018 the baseline all cause mortality rate in the most deprived decile was 1.9 times that in the least deprived decile in both males and females. This is smaller than the ratio for COVID-19 mortality rates indicating that the level of inequality in COVID-19 mortality rates is greater than that for all cause mortality in previous years.



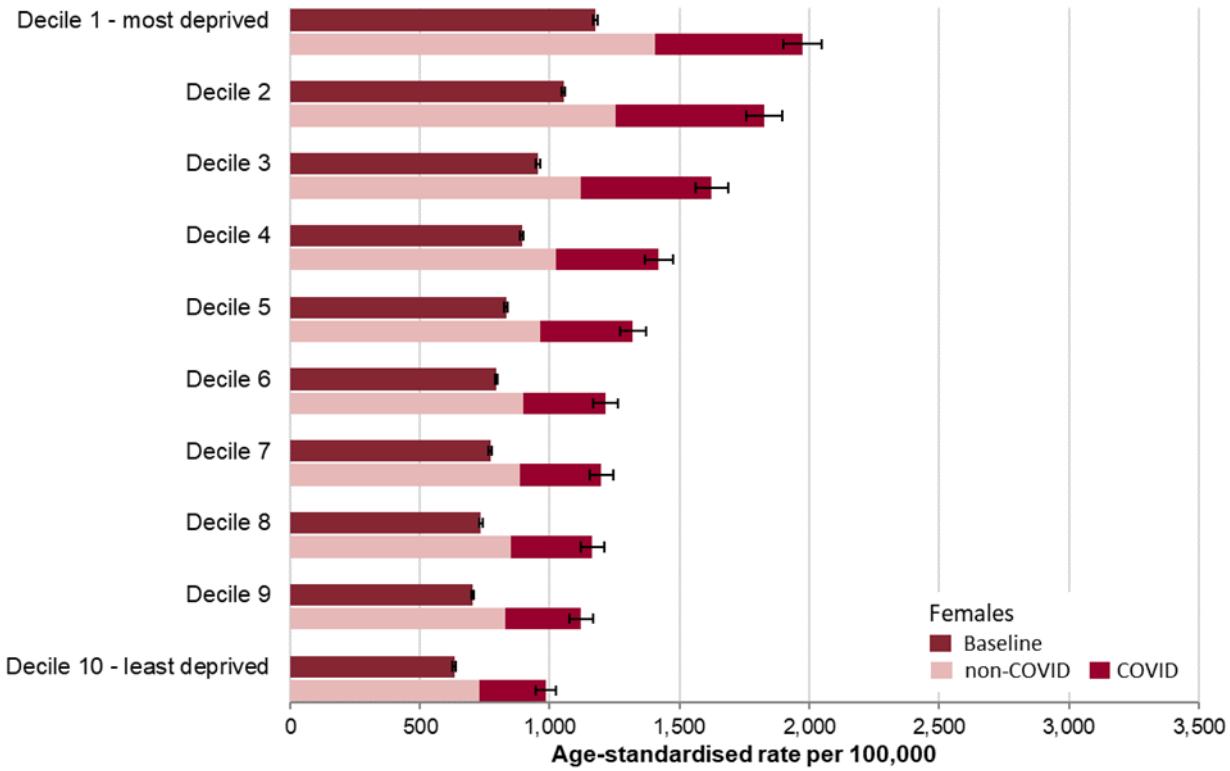



**Figure 3.5A and 3.5B.** Age-standardised mortality rates for all cause deaths and deaths mentioning COVID-19, 21 March to 8 May 2020, compared with baseline mortality rates (2014 to 2018), by deprivation decile and sex, England. Source: Public Health England analysis of ONS death registration data

## 3.6 Excess mortality

The PHE excess mortality model shows that between 20 March and 7 May 2020, there was excess mortality among all five deprivation quintiles. The crude number of excess deaths ranges from 10,678 in the most deprived quintile areas to 8,621 in the least deprived. This is a slightly larger relative increase in the most deprived quintile. The number of deaths with COVID-19 mentioned as a percentage of these excess deaths ranges from 72-77% across the quintiles.

# 4. Ethnicity

## 4.1 Main messages

The highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

An analysis of survival among confirmed COVID-19 cases shows that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.

Death rates from COVID-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all cause mortality rates were lower in Asian and Black ethnic groups. Therefore, the inequality in COVID-19 mortality between ethnic groups is the opposite of that seen for all causes of death in previous years.

Comparing to previous years, all cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.

These analyses were not able to include the effect of occupation. This is an important shortcoming because occupation is associated with risk of being exposed to COVID-19 and we know some key occupations have a high proportion of workers from BAME groups.

These analyses were also not able to include the effect of comorbidities or obesity. These are also important factors because they are associated with the risk of death and are more commonly seen in some BAME groups. Other evidence has shown that when these are included, the difference in risk of death among hospitalised patients is greatly reduced.

## 4.2 Background

Evidence suggests that COVID-19 may have a disproportionate impact on people from Black, Asian and minority ethnic (BAME) groups. The Intensive Care National Audit and

Research Centre (ICNARC) report published on 22 May found that Black and Asian patients were over-represented among those critically ill with confirmed COVID-19 receiving advanced respiratory support. The report found that 15.2% and 9.7% of critically ill patients were from Asian and Black ethnic groups respectively (2).

Some evidence also suggests the risk of death from COVID-19 is higher among people of BAME groups (15) and an ONS analysis showed that, when taking age into account, Black males were 4.2 times more likely to die from a COVID-19-related death than White males (16). The risk was also increased for people of Bangladeshi and Pakistani, Indian and Mixed ethnic groups. However, an analysis of over 10,000 patients with COVID-19 admitted to intensive care in UK hospitals suggests that, once age, sex, obesity and comorbidities are taken into account, there is no difference in the likelihood of being admitted to intensive care or of dying between ethnic groups (17).

The relationship between ethnicity and health is complex and likely to be the result of a combination of factors. Firstly, people of BAME communities are likely to be at increased risk of acquiring the infection. This is because BAME people are more likely to live in urban areas (18), in overcrowded households (19), in deprived areas (20), and have jobs that expose them to higher risk (21). People of BAME groups are also more likely than people of White British ethnicity to be born abroad (22), which means they may face additional barriers in accessing services that are created by, for example, cultural and language differences.

Secondly, people of BAME communities are also likely to be at increased risk of poorer outcomes once they acquire the infection. For example, some co-morbidities which increase the risk of poorer outcomes from COVID-19 are more common among certain ethnic groups. People of Bangladeshi and Pakistani background have higher rates of cardiovascular disease than people from White British ethnicity (23), and people of Black Caribbean and Black African ethnicity have higher rates of hypertension compared with other ethnic groups (24). Data from the National Diabetes Audit suggests that type II diabetes prevalence is higher in people from BAME communities (25).

Most analyses in this section of the review look at five broad ethnic groups: White / White British, Black / Black British, Asian / Asian British, Mixed / Multiple Ethnic groups and Other ethnic groups. The survival analysis looks at sixteen smaller ethnic groups. These are based on the data available from different sources. Appendix B and the data sources and methodologies section outline these groups and how they were collapsed.

## 4.3 Cases

This section presents laboratory confirmed cases under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well

as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

It was possible to assign ethnicity to 127,821 (91.9%) of the 139,086 individuals who had tested positive for SARS-CoV-2 by 13 May 2020. Figure 4.1 shows the weekly number of positive cases by ethnic group since the start of the pandemic. For Black and Other ethnic groups, the highest weekly number of cases was reported in week ending 4 April and for all other ethnic groups the highest weekly number of cases was reported in week ending 11 April.

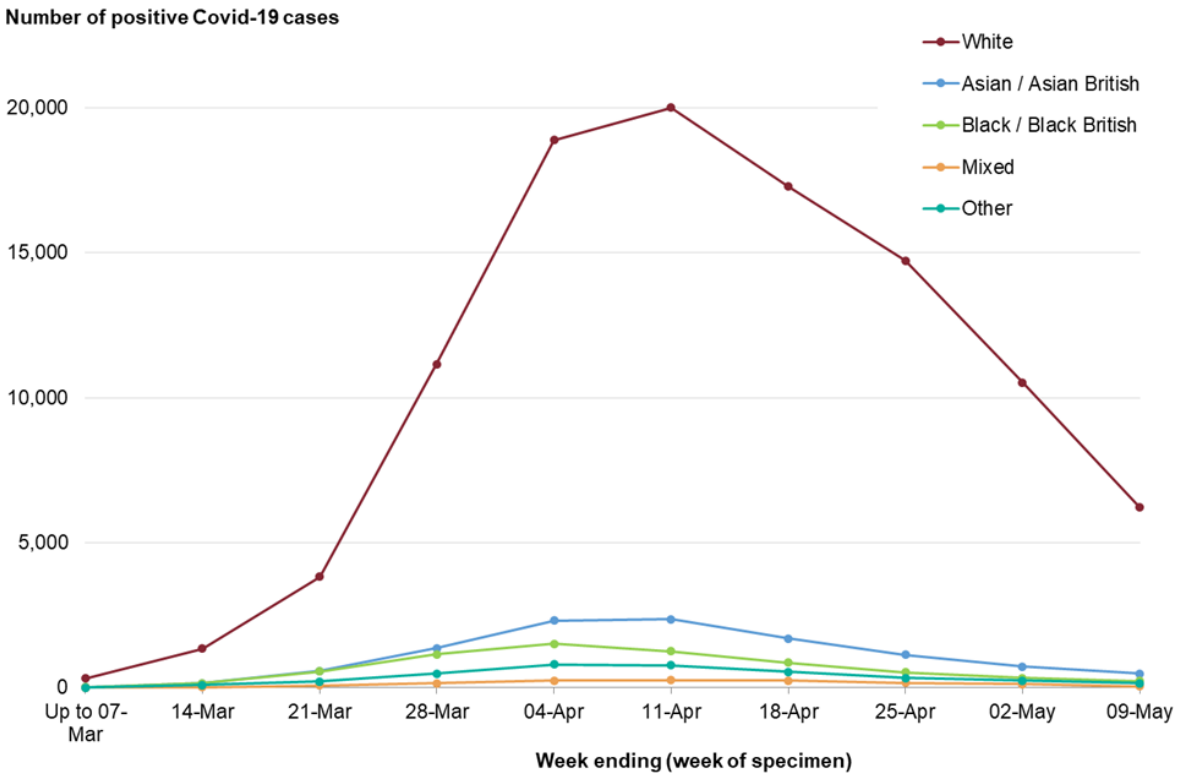



**Figure 4.1.** Number of positive confirmed cases by ethnic group and week, as of 9 May 2020, England. Source: Public Health England Second Generation Surveillance System. Note: The last week of data was removed as it was an incomplete week.

Figure 4.2 shows the age standardised diagnoses rates by ethnic group. After adjustment by age, the highest diagnosis rates of COVID-19 per 100,000 population were in people of Other ethnic groups (1,076 in women and 1,101 in men) followed by people of Black ethnic groups (486 in females and 649 in males). This compared to 220 per 100,000 among White females and 224 among White males.

These results are not adjusted for some factors that may influence the likelihood of becoming infected, such as geographical location. The rates in the Other ethnic group

are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases data and the population data used to calculate the rates.

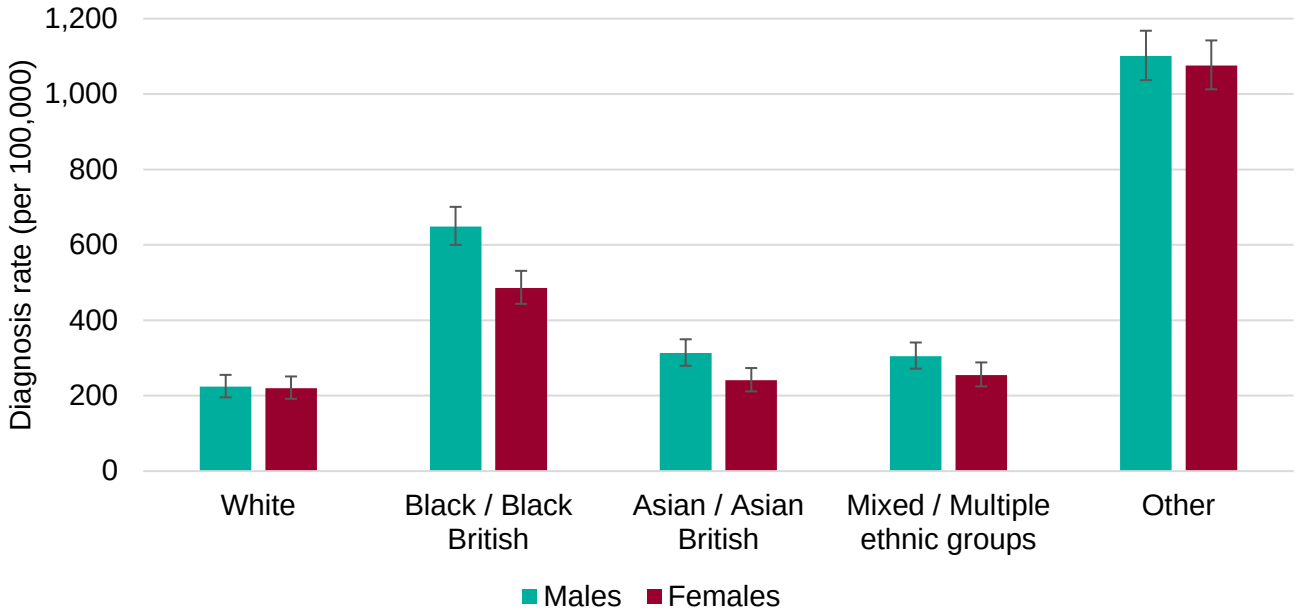



**Figure 4.2.** Age standardised diagnosis rates by ethnicity and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

## 4.4 Hospitalisations

As of 19 May, 42 trusts had reported lower level of care patients (defined as admission to any hospital ward, excluding ICU or HDU), and 94 trusts contributed ICU/HDU (critical care) patient data to the COVID-19 Hospitalisations in England surveillance system (CHESS). Reporting varies by trusts and the majority of trusts in London do not consistently report to CHESS which will impact on the representativeness of the hospitalised cases. The data presented in this section have not been adjusted for this, which means findings must be interpreted with caution.

The lower level of care subset contained 8,508 cases of which 7,617 (89.5%) could be linked to Hospital Episode Statistics (HES) to assign ethnicity. The critical care subset contained 3,978 cases of which 3,219 (80.9%) could be linked to HES to assign ethnicity.

Among cases hospitalised in lower level of care, 11% were of Black, Asian and other Minority Ethnic (BAME) groups; however, this proportion was 36% of those admitted to critical care (Figure 4.3). Confirmed cases among BAME groups tend to be younger than White ethnic groups, which is likely to explain some of this difference, as might other factors such as comorbidities.

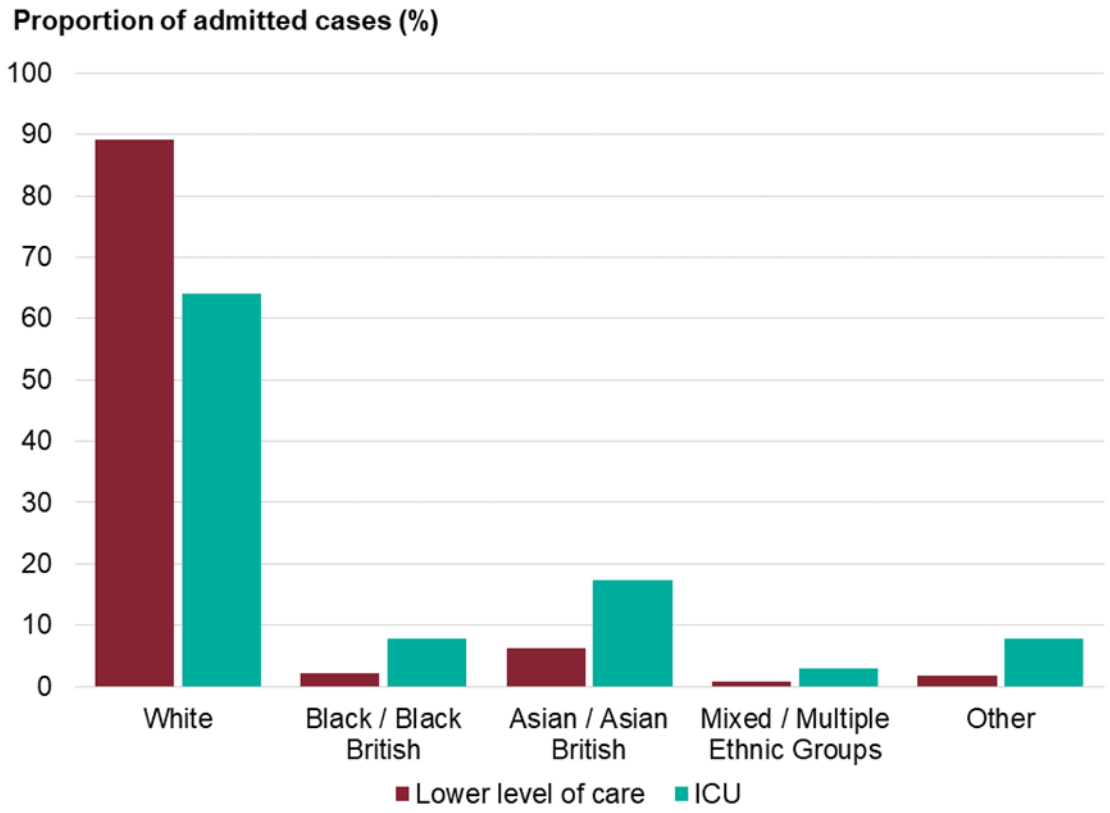



**Figure 4.3.** Laboratory confirmed admissions for COVID-19 to acute trusts, by level of care and ethnicity, England, as of 19 May 2020. Source: Public Health England COVID-19 Hospitalisations in England surveillance system (CHESS).

## 4.5 Deaths in confirmed cases

There were 29,673 deaths reported to PHE by 13 May 2020 of which it was possible to obtain ethnicity for 29,500 (99.4%). For all ethnic groups, the highest weekly number of deaths was recorded on week ending 11 April, except for Mixed / Multiple ethnic groups who had an equally high number on week ending 18 April (Figure 4.4).

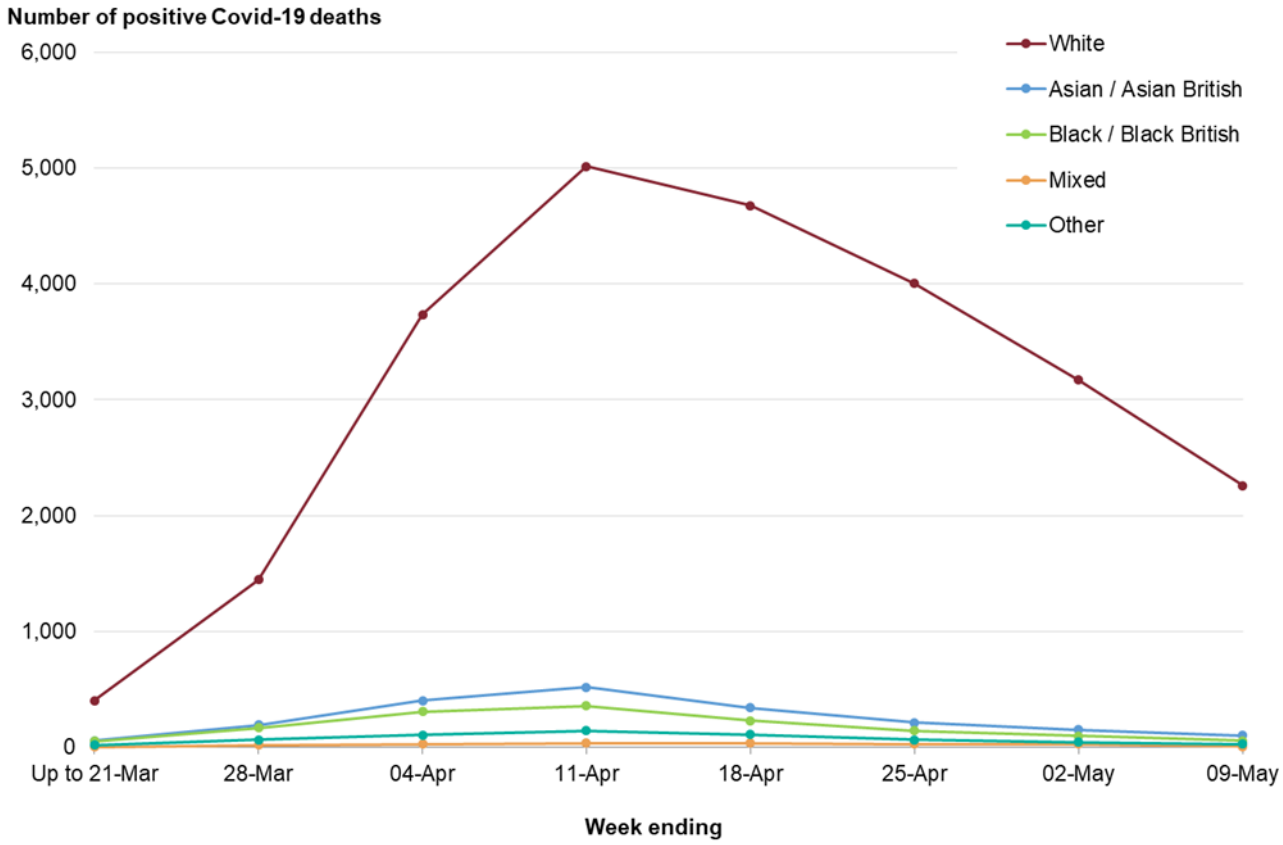



**Figure 4.4.** Number of deaths in laboratory confirmed COVID-19 cases by ethnicity and week, as of 9 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System. Note: The last week of data was removed as it was an incomplete week.

The highest age standardised deaths rates in confirmed cases per 100,000 population were among people of Other ethnic groups (234 in females and 427 in males) followed by people of Black ethnic groups (119 in females and 257 in males), Asian ethnic groups (78 in females and 163 in males), Mixed ethnic groups (58 in females and 116 in males) and White ethnic groups (36 in females and 70 in males) (Figure 4.5).

The rates in the Other ethnic group are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases/mortality data and the population data used to calculate the rates.

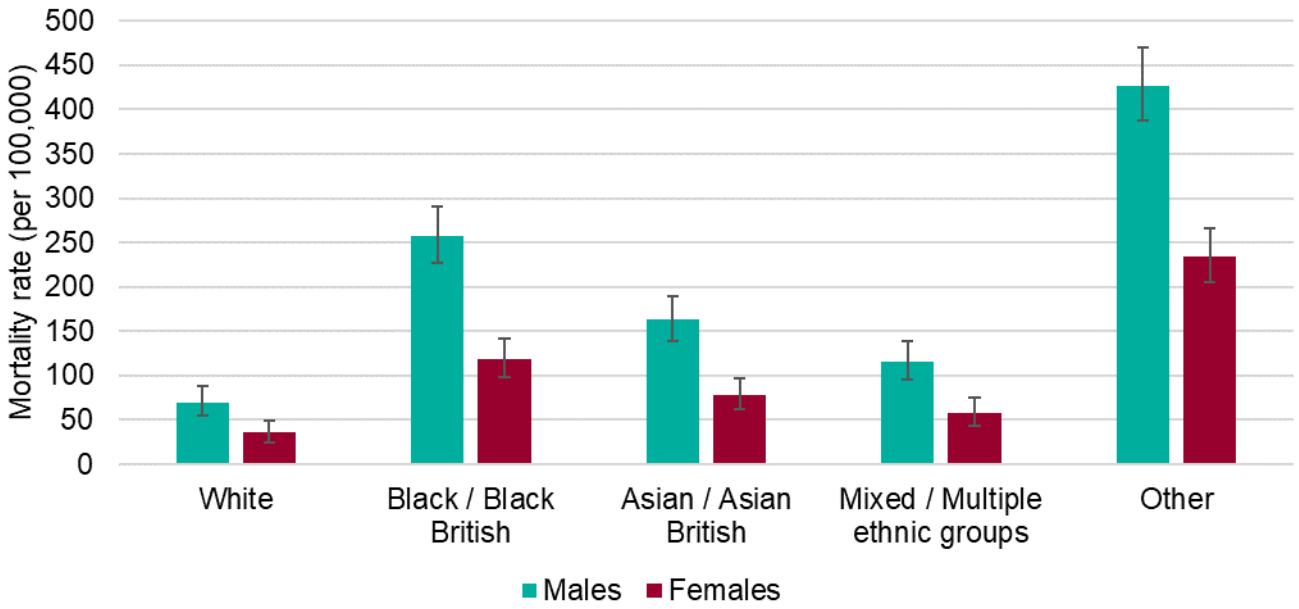



**Figure 4.5.** Age standardised mortality rates in laboratory confirmed COVID-19 cases by ethnicity and sex, as of 13 May, England. Source: Public Health England: COVID-19 Specific Mortality Surveillance System.

An analysis of survival among people with confirmed COVID-19 by sex, age group, ethnicity, deprivation and region, shows that, after taking these factors into account, some ethnic groups still had a higher risk of death than others (Appendix A). This analysis looked at 16 ethnicity categories and found that, when compared to White British ethnicity, people of Bangladeshi ethnicity had twice the risk of death. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British (Appendix A, table A1).

When looking only at the working age population (between 20 and 64 years old), the increased risk of death is seen among people of Bangladeshi ethnicity (80% higher risk than White British ethnicity), Black Other ethnicity, Pakistani ethnicity (both 50% higher) and Black Caribbean ethnicity (30% higher) (Appendix A, table A2).

While this analysis adjusts for many important factors such as age and deprivation, it does not adjust for factors such as comorbidities and obesity, which are likely to have an important impact on the different risk of dying between ethnic groups.

## 4.6 Comparison with inequalities in previous years

This section uses deaths reported by the Office for National Statistics (ONS) to compare inequalities in death rates mentioning COVID-19 on the death certificate with inequalities in all cause death rates for previous years (the ‘baseline all cause’ figure). Ethnicity is not recorded at death registration, so this information was obtained through

linkage to Hospital Episode Statistics. It was possible to obtain ethnicity information for 97% of all cause deaths.

Figures 4.6A and 4.6B show age standardised mortality rates for all causes of death and for deaths mentioning COVID-19 by ethnic group between 21 March 2020 and 1 May 2020. They also show the baseline all cause rate using the average annual all cause mortality rates for 2014 to 2018.

Death rates from COVID-19 were higher in people of Asian, Black, Mixed and Other ethnic groups than White ethnic groups (Figure 4.6A and 4.6B). Black males were 3.9 times more likely to die than the White group, compared with 2.5 times in Asian males. Among females, death rates were 3.3 times higher in the Black ethnic group, and 2.3 times higher in the Asian ethnic group than the White group. These inequalities are broadly consistent with the pattern of deaths in confirmed cases and the findings from ONS before adjustment for other factors (16).

However, the baseline all cause rates show lower mortality in Asian and Black ethnic groups than the White group, therefore the inequality in COVID-19 mortality between these groups is the opposite of that seen for all causes of death in previous years.

The Other ethnic group also had higher mortality rates from both all causes and COVID-19 than the White group. The rates in the Other ethnic group are likely to be an overestimate due to the difference in the source of allocating ethnicity codes to the mortality data and the population data used to calculate the rates. This may explain the high mortality rates in the Other group, which cannot be interpreted and requires further investigation.

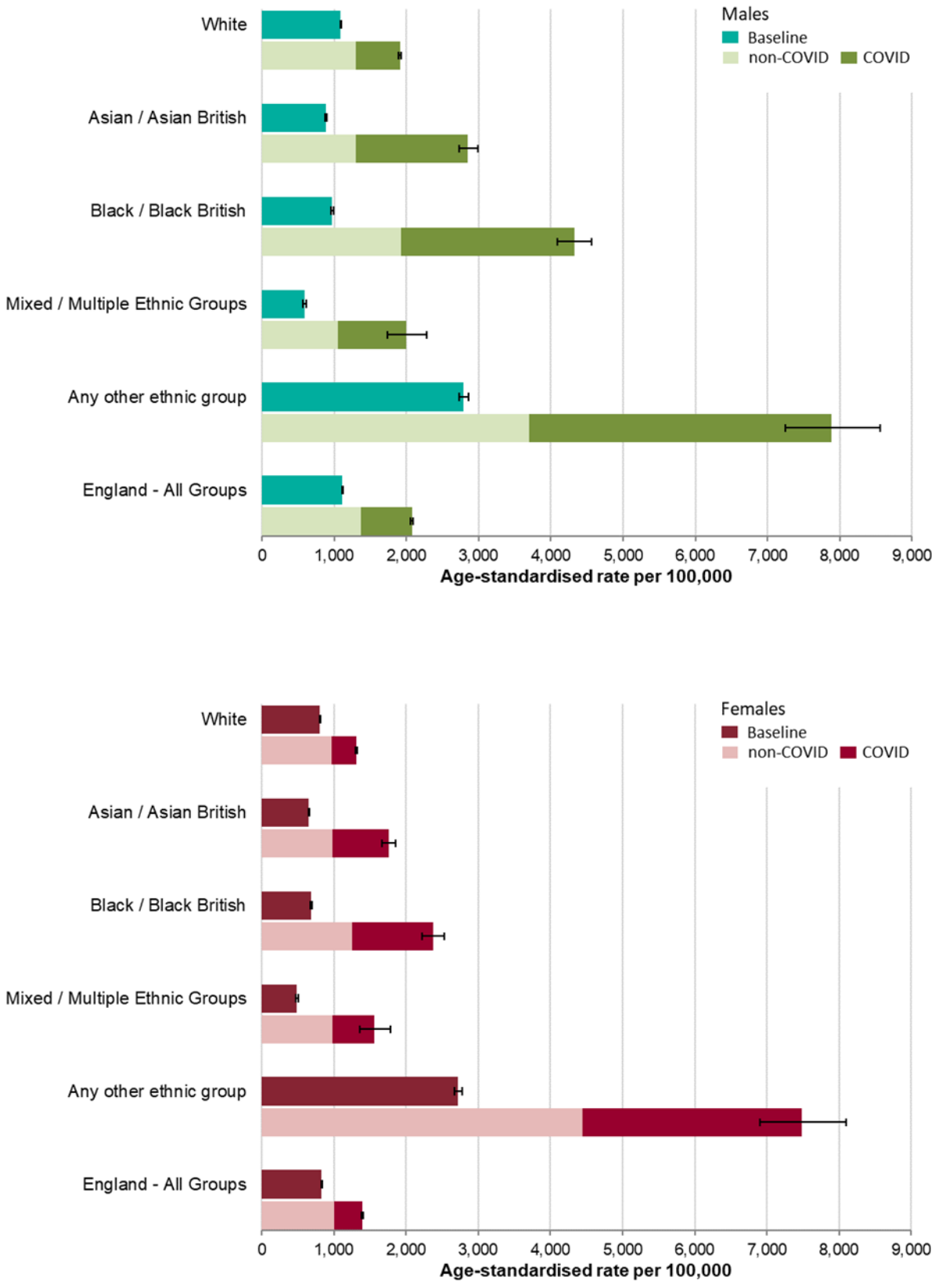



**Figure 4.6A and 4.6B.** Age-standardised mortality rates for all cause deaths and deaths mentioning COVID-19, 21 March to 1 May 2020, compared with baseline mortality rates (2014 to 2018), by ethnicity and sex, England. Source: Public Health England analysis of ONS death registration data.

## 4.7 Excess mortality

The excess mortality model shows the number of excess deaths by sex and ethnic group in the period 20 March to 7 May against the number of deaths that would be expected for corresponding dates in 2014 to 2018 (Figure 4.7). It also quantifies how many deaths had COVID-19 mentioned on the death certificate.

Overall, the model suggests there have been 43,941 excess deaths among the White group, 2,301 Black, 3,083 Asian, 385 Mixed and 1,038 in the Other ethnic group. Deaths in Black males were 3.9 times higher than expected in this period, compared with 2.9 times higher in Asian males and 1.7 times higher in White males. Among females, deaths were between 2.7-2.8 times higher in Black, Mixed and Other ethnic groups in this period, compared with 2.4 in Asian and 1.6 in White females.

The percentage of these excess deaths for which COVID-19 is mentioned is highest in males in the Other ethnic group (94.0%) and Asian males (80.9%), and lowest in Mixed females (58.2%) and females in the Other ethnic group (62.8%).

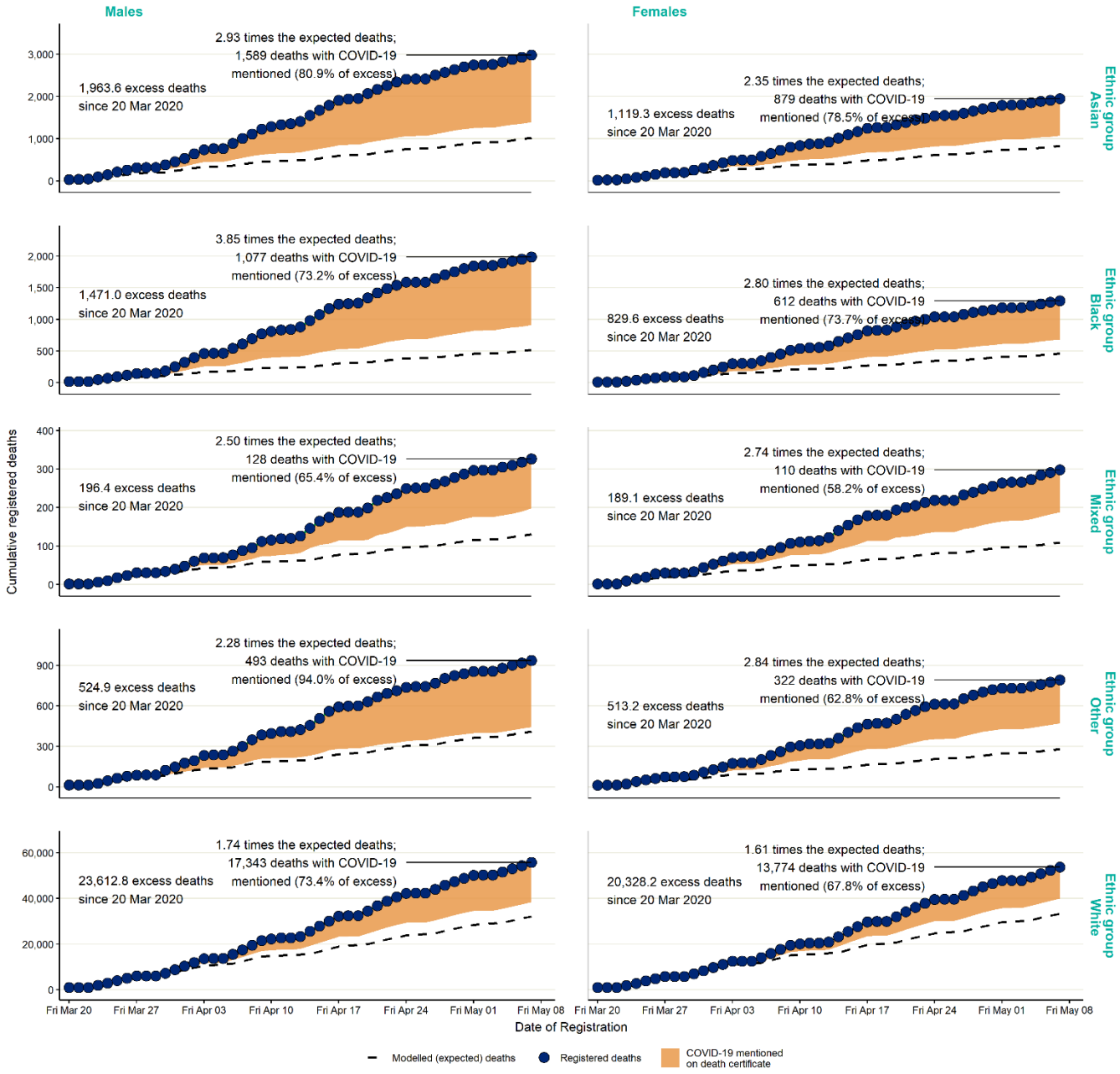



**Figure 4.7.** Cumulative all cause deaths by date of registration by ethnicity, 20 March to 7 May 2020, England. Source: Public Health England excess mortality model based on ONS death registration data.

# 5. Occupation

## 5.1 Main messages

A total of 10,841 COVID-19 cases were identified in nurses, midwives and nursing associates, representing 1.9% of the health professionals who are registered with the Nursing and Midwifery Council (NMC). By ethnic group, this represents 3.9% of nurses, midwives and nursing associates of Asian ethnic groups, 3.1% of Other ethnic groups, 1.7% of White ethnic groups and 1.5% of both Black and Mixed ethnic groups. This analysis did not look at the possible reasons behind these differences, which may be driven by factors like geography or nature of individuals' roles.

ONS reported that men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19. Our analysis expands on this and shows that nursing auxiliaries and assistants have seen an increase in all cause deaths since 2014 to 2018. For many occupations, however, the number of deaths is too small to draw meaningful conclusions and further analysis will be required.

## 5.2 Background

Some occupations require close or frequent contact with other individuals, which leads to an increased risk of COVID-19 infection. Early reports suggest that occupational exposure accounts for some infections (26), with healthcare workers (HCW) being particularly at risk of infection, but also individuals working in other people-facing occupations such as retail, hospitality, transport and security. Epidemiological data from European countries suggest that HCW may account for 9% to 26% of those infected (27).

ONS created an estimate of exposure to disease and physical proximity for UK occupations, which provides an indication of which roles may be more likely to come into contact with people with COVID-19 (21). HCW are exposed to disease on a daily basis and require close contact with others. Other occupations, such as those working in the emergency services (police, fire, ambulance), social care and educators, and other occupations such as bar staff and hairdressers, also have close contact with others but are less likely to be exposed to people with the disease when compared to HCW.

For some people in these occupations, social distancing measures have substantially reduced their physical proximity to others. Among workers in occupations that are more

likely to be in frequent contact with people and exposed to disease, three in four are women and one in five are from BAME groups (21). An analysis of 119 deaths of NHS staff showed a disproportionately high number of BAME staff among those who had died (28).

Despite the differences in likelihood of exposure, the ONS Coronavirus (COVID-19) Infection Survey for England found no evidence of a difference between the proportions testing positive for patient-facing healthcare or resident-facing social care roles and people not working in these roles (29). These are provisional results and there is a high level of uncertainty about this estimate.

ONS has recently reported that men working in low skilled occupations had the highest rate of death involving COVID-19 up to 20 April 2020 (52). Men working in some specific occupations had significantly raised rates of death involving COVID-19, including security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, and lower skilled occupations in construction and processing plants. Men and women working in social care were also reported to have had significantly raised rates of death involving COVID-19. HCW were not found by ONS to have higher rates of COVID-19-related death when compared with those of the same age and sex in the general population.

## 5.3 Cases in nurses, midwives and nursing associates

This section presents laboratory confirmed cases that were matched to the professionals on the Nursing and Midwifery Council (NMC) register on 14 May 2020. The cases were identified under Pillar 1 testing. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease, rather than all of those who get infected.

A total of 10,841 diagnosed COVID-19 cases in nurses, midwives and nursing associates were identified, 9,385 of whom were in females. This represents 1.9% of the professionals on NMC register. The median age of cases was 45.5 and 45.1 for males and females, respectively.

Figure 5.1 shows the proportion of COVID-19 cases among registered nurses, midwives and nursing associates by ethnic group. This proportion was highest among those of Asian ethnic groups (3.9%), followed by Other ethnic groups (3.1%), White ethnic groups (1.7%) and Black and Mixed ethnic groups (both with 1.5%).

These results are not adjusted for factors that may influence the likelihood of becoming infected, such as age, sex, geographical location or nature of individuals' professional roles.

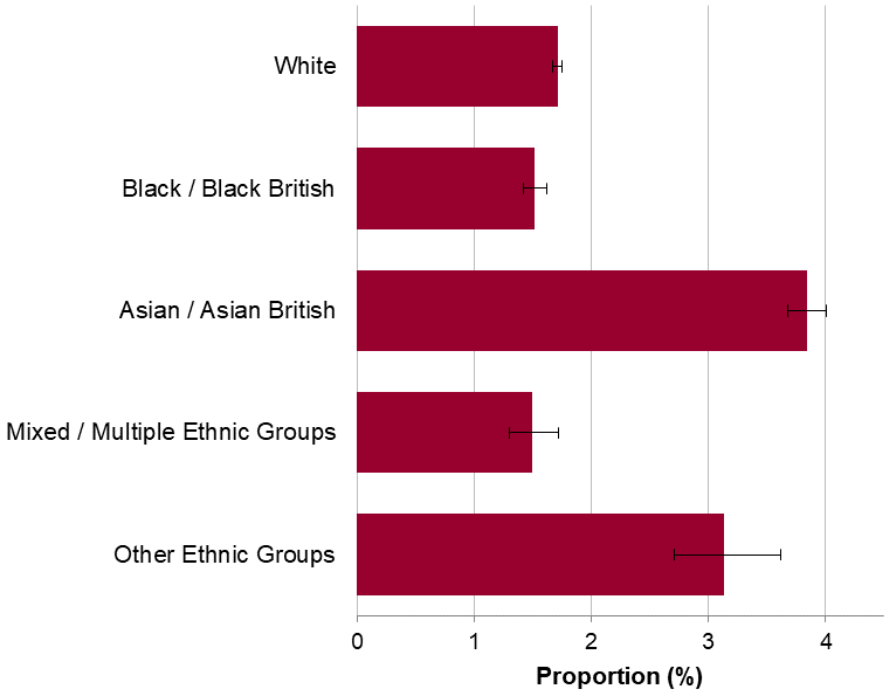



**Figure 5.1.** Proportion of registered nurses, midwives and nursing associates with laboratory confirmed COVID-19 by ethnic group, as of 18 May 2020, England. Source: NMC register and Public Health England Second Generation Surveillance System.

## 5.4 Mortality by occupation

This section examines the relative increase in all cause death registrations by occupation in the period 21 March to 8 May 2020, compared with the average for the same period in the years 2014 to 2018. Deaths in people aged 20 to 64 in 2020 were 1.5 times higher than average.

For three occupations the relative increase in deaths in 2020 was significantly higher than the average of 1.5: Caring Personal Services, Elementary Security Occupations, and Road Transport Drivers (Table 5.1). Of these groups, the biggest increase was for Elementary Security Occupations, where deaths were 2.3 times higher in 2020 than in the same period in 2014 to 2018. Workers in these groups were also identified in the ONS analysis as having high rates of death involving COVID-19.

Within these groups, there were three occupational ‘unit groups’ where the increase in deaths in 2020 was significantly higher than the increase for everyone aged 20 to 64. These were nursing auxiliaries and assistants, security guards and related occupations, and taxi and cab drivers and chauffeurs.

**Table 5.1.** Relative increase in all cause deaths registered between 21 March and 8 May 2014 to 2018 and 2020, for people aged 20-64, by occupational groups, England.* Source: Public Health England analysis of ONS death registration data

| Occupation | Deaths 2014-18 average all causes | Deaths 2020 all causes | Relative increase between 2014-18 and 2020 | Lower 95% confidence interval | Upper 95% confidence interval |
|---|---|---|---|---|---|
| Caring Personal Services | 414 | 760 | 1.8 | 1.6 | 2.1 |
| Nursing auxiliaries and assistants | 52 | 128 | 2.5 | 1.8 | 3.4 |
| Elementary Security Occupations | 117 | 267 | 2.3 | 1.8 | 2.8 |
| Security guards and related occupations | 80 | 209 | 2.6 | 2.0 | 3.4 |
| Road Transport Drivers | 384 | 694 | 1.8 | 1.6 | 2.0 |
| Taxi and cab drivers and chauffeurs | 87 | 217 | 2.5 | 1.9 | 3.2 |
| **All people aged 20-64** | **9,440** | **14,409** | **1.5** | **1.5** | **1.6** |

*Occupations are only listed where the relative increase was significantly higher than the average for all persons. Results for all occupational groups can be found in the Table 5a and 5b in the data pack.

Although only these small number of occupations had a significant relative increase in deaths in 2020, other occupations have seen a large increase in their absolute number of deaths since the start of the pandemic. These are listed in Table 5a and 5b in the data pack. These tables also include the number of deaths in 2020 where COVID-19 was recorded on the death certificate, and the percentage of the excess deaths in 2020 which were due to COVID-19.

The largest absolute increase was for workers in Caring Personal Services. There were 760 deaths from all causes among these workers in the period 21 March to 8 May 2020 for people aged 20 to 64. This is 346 more than in the same period in 2014 to 2018 and 74% had COVID-19 recorded as a cause of death.

For workers in Construction and Building Trades, the number of deaths related to COVID-19 was slightly higher than the number of excess deaths. This indicates that deaths from other causes have gone down which may be due to a reduced risk of occupational related injuries over this time period.

As noted above, ONS did not find that healthcare workers had higher rates of death involving COVID-19 compared with the general population. The ONS definition of HCW includes people in 26 different occupational groups, who are likely to have had different levels of contact with individuals, particularly during the pandemic. Table 5b in the data pack shows that the relative increase in the number of deaths registered for medical practitioners was 2.5 times higher than in 2014 to 2018. This is a larger increase than the average for all people aged 20-64 (1.5) but is not statistically significant. The relative increase for nurses was 1.7. This was also not significantly higher than average, but nurses are one of the occupations with the highest absolute increase in deaths between 2014 to 2018 and 2020 (from 133 to 233).

# 6. Inclusion health groups

## 6.1 Main messages

For people born outside of the UK and Ireland, the relative increase in deaths in 21 March to 8 May 2020 was higher than the average. The biggest relative increase was for people born in Central and Western Africa (which includes Nigeria, Ghana and Somalia), the Caribbean, South East Asia (which includes Malaysia, the Philippines and Vietnam), the Middle East and South and Eastern Africa (which includes South Africa, Zimbabwe and Kenya).

There were 54 men and 13 women diagnosed with COVID-19 with no fixed abode, likely to be rough sleepers. We estimate that this represents 2% and 1.5% of the known population of women and men who experienced rough sleeping in 2019.

## 6.2 Introduction

Populations who are socially excluded, such as people who experience homelessness and vulnerable migrants, tend to have the poorest health outcomes, putting them at the extreme end of the gradient of health inequalities (30). This is a consequence of being exposed to multiple, overlapping risk factors, such as facing barriers in access to services, stigma and discrimination.

Notably, people who are socially excluded are not consistently recorded in electronic records, often making them effectively invisible for policy and service planning purposes (31). Nevertheless, there is strong evidence that inclusion health groups have very high levels of morbidity and mortality, often with multiple and complex needs including overlapping mental and physical ill-health, and substance dependency (32). This puts these populations at increased risk from the consequences of emergencies, such as pandemics.

A recent modelling exercise, for example, estimated that in a “do nothing” scenario, 34% of people living in hostels and sleeping rough would be infected with COVID-19, leading to over four thousand hospital admissions (33). Other countries have reported outbreaks in homeless shelters (34) and among migrant workers (35).

## 6.3 Mortality in Migrants

This section uses deaths reported by ONS to compare deaths between 21 March and 8 May 2020 with deaths in previous years by country of birth. Being born outside of the UK does not necessarily mean a person is a vulnerable migrant, but migration is a

factor that impacts on people's health. In the UK resident population, there is some association between ethnicity and being born abroad.

In the period 21 March to 8 May 2020, the number of death registrations from all causes for people in England was 1.7 times higher than in the same period for the average of the years 2014 to 2018. For people born in England, Scotland, Wales, Northern Ireland, and Ireland, the relative increase was similar to this (Figure 6.1). For all other groups of countries, the relative increase was higher than the average and in almost all cases this increase was significantly higher.

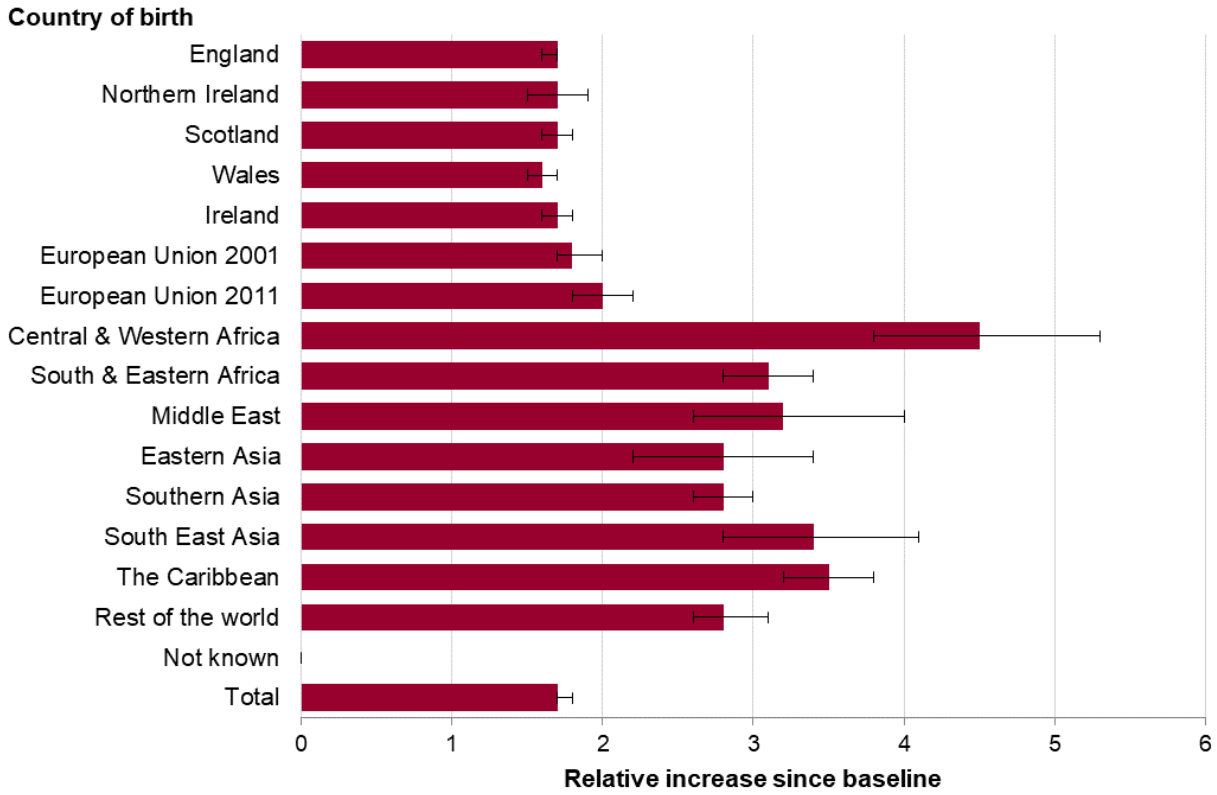



**Figure 6.1.** Relative increase in total deaths registered in England in 2020 compared to the average for 2014 to 2018, 21 March to 8 May, by country of birth.* Source: Public Health England analysis of ONS death registration data.
(*The numbers of deaths in each of the country groupings can be found in Table 6a in the data pack. The list of countries in each of the groups can be found in Table 6b in the data pack.)

The biggest relative increase was for people born in Central and Western Africa (4.5 times higher in 2020 than in 2014 to 2018). This group of countries includes Nigeria, Ghana and Somalia. For people born in four other groups of countries, deaths in 2020 were more than 3 times higher than the equivalent period in 2014 to 2018: the Caribbean (3.5), South East Asia, which includes Malaysia, the Philippines and Vietnam (3.4), the Middle East (3.2) and South and Eastern Africa, which includes South Africa, Zimbabwe and Kenya (3.1).

For people born in the European Union 2001, the relative increase was 1.8 times higher, and this was the only group of countries not significantly higher than the average for England. This group includes all countries which were EU members in 2001. Countries which joined the EU between 2001 and 2011 (such as Poland and the 9 other countries which joined in 2004) are included in the European Union 2011 group, for which the relative increase was 2.0.

## 6.4 People with no fixed abode

Overall, there were 67 diagnoses of COVID-19 among people assigned a ‘no fixed abode’ (NFA) code. Of these, 54 (80.6%) were men.

Taking into account the estimated number of people sleeping rough in England in Autumn 2019, this represents 1.6% of the rough sleeping population. This is lower for men (1.5%) than women (2.1%) (Figure 6.2).

These figures are subject to uncertainty and should be treated as estimates.

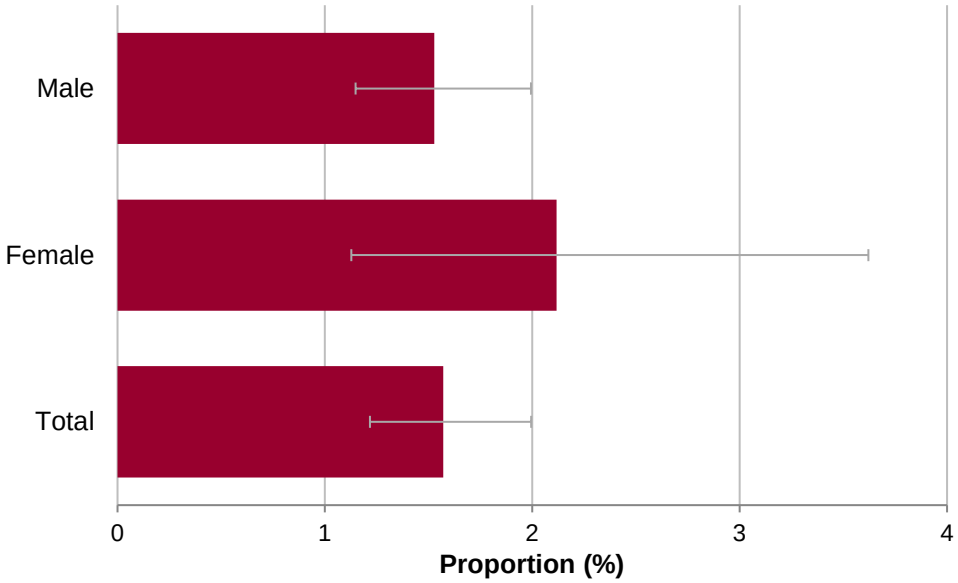



**Figure 6.2.** Proportion of cases assigned a no fixed abode code per 100 population of rough sleepers by sex and in total as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System and Ministry of Housing, Communities and Local Government.

# 7. Deaths in care homes

## 7.1 Main messages

By the 10 April 2020, deaths in care homes accounted for 10% of all deaths from COVID-19 in England. However, this percentage has increased over time and in the week ending 8 May care homes accounted for a much greater proportion (43%). The number of deaths from COVID-19 in hospitals peaked in the week ending 17 April, but the number in care homes peaked a week later.

The excess mortality model suggests that there have been 2.3 times the number of deaths in care homes than expected between 20 March and 7 May which equates to around 20,457 excess deaths. The number of COVID-19 deaths over this period is equivalent to 46.4% of the excess, suggesting that there were many excess deaths from other causes or an under-reporting of deaths from COVID-19.

## 7.2 Background

Between 9 March and 17 May 2020 there were 5,887 outbreaks of COVID-19 reported in care homes in England (36). There are 15,514 care homes in England, so this indicates that 38% had experienced an outbreak.

Many countries have seen a significant proportion of COVID-19 deaths in care homes or in care home residents and this proportion seems to be higher in countries where there have been a larger number of deaths (37).

## 7.3 Death registrations

Data reported by ONS show that 9,492 deaths mentioning COVID-19 on the death certificate that occurred in care homes were registered up until 8 May 2020. This is 27% of all COVID-19 deaths (7). This figure will not include all deaths of care home residents who may die elsewhere.

The number of deaths from COVID-19 in hospitals has been greater than the number in care homes each week between week ending 27 March and 8 May (Figure 7.1). The number of deaths from COVID-19 in hospitals peaked in the week ending 17 April, but the number in care homes peaked a week later.

By the 10 April 2020, deaths in care homes accounted for 10% of all deaths from COVID-19 in England. However, this percentage has increased over time and in week

ending 8 May 2020 deaths in care homes accounted for a much greater proportion (43%), compared with 50% for hospitals.

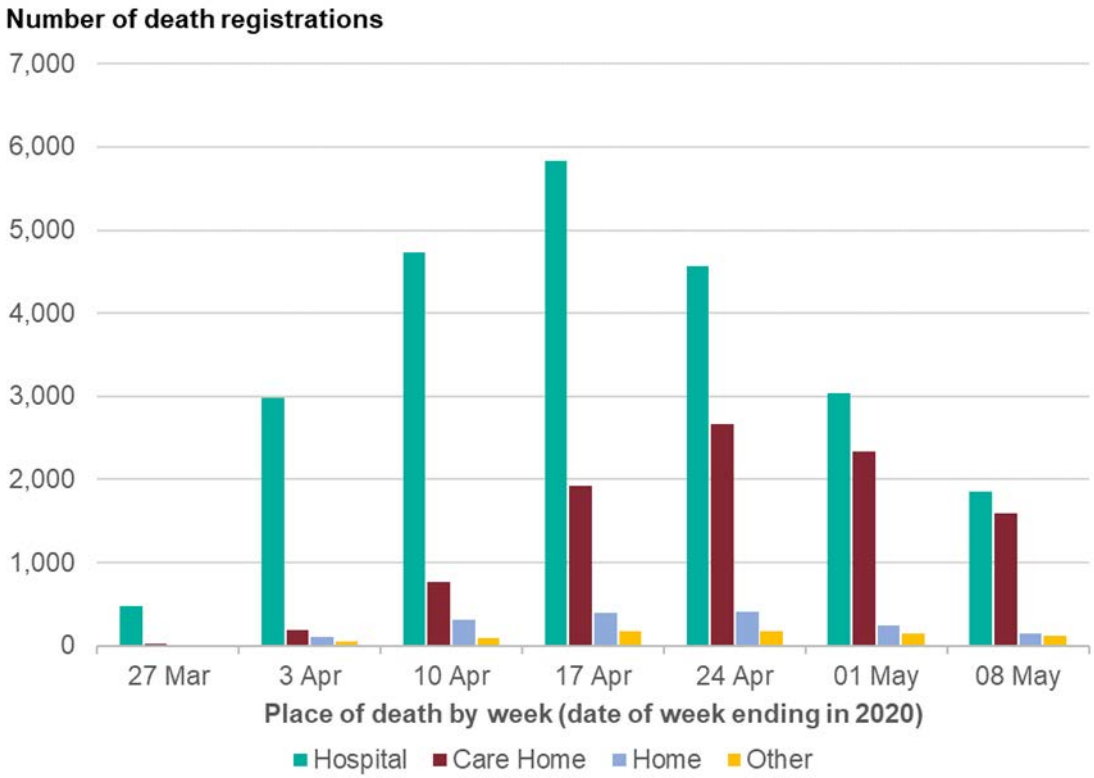



**Figure 7.1**. Weekly provisional death registrations for deaths where COVID-19 was mentioned on the death certificate, by place of occurrence, data up to 8 May 2020, England. Source: Public Health England analysis of ONS death registration data.

The Care Quality Commission report on deaths of care home residents, regardless of where the death took place. Between 11 April and 8 May 2020, there were 27,817 deaths of care home residents (38). This is 3,024 more than the number of deaths occurring in care homes reported by ONS during the same period (24,793). During this period, 73% of care home residents died in care homes, 13% died in hospital and for the majority of the remainder information on place of death was not available.

## 7.4 Excess mortality

Table 7.1 shows results from the excess mortality model and includes the number of excess deaths by place of death in the period 20 March to 7 May against the number of deaths that would be expected for corresponding dates in 2015 to 2019. It also quantifies how many deaths have COVID-19 mentioned on the death certificate.

**Table 7.1.** Cumulative all cause deaths by date of registration and place of death, 20 March to 7 May 2020, England. Source: Public Health England excess mortality model based on ONS death registration data.*

| | Observed deaths | Expected deaths | Ratio observed/ expected | Excess deaths | COVID-19 deaths | COVID-19 deaths as % excess |
|---|---|---|---|---|---|---|
| Home | 26400 | 16858 | 1.6 | 9542 | 1630 | 17.1% |
| Care home | 35933 | 15476 | 2.3 | 20457 | 9496 | 46.4% |
| Hospital | 47913 | 31897 | 1.5 | 16016 | 23569 | >100% |
| Hospice | 3617 | 4006 | 0.9 | -389 | 453 | No excess deaths |
| Other places | 2406 | 1674 | 1.4 | 732 | 291 | 39.8% |
| Total | 116269 | 69911 | 1.7 | 46358 | 35439 | 76.4% |

*Note that the model for place of death is slightly different from other models and therefore the number of excess deaths is slightly different.

Overall the model suggests that there have been 20,457 excess deaths in care homes between 20 March and 7 May 2020 and 16,016 in hospitals. The care home finding is consistent with the finding reported in section 1, that 75% of excess deaths are in people aged 75 and over. It is not possible to say whether these excess deaths in care homes have been concentrated in a few with outbreaks or distributed among many. There have been no excess deaths in hospices.

The number of COVID-19 deaths in hospitals is greater than the estimated number of excess deaths. This suggests that deaths in hospitals from causes other than COVID-19 have reduced over this period or that COVID-19 has also contributed to deaths from other causes.

In care homes the number of COVID-19 deaths is equivalent to 46.4% of the excess. This is consistent with figures reported by ONS (39) and suggests that there has been an increase in deaths from other causes over this period in care homes or an under-reporting of COVID-19 on death certificates. Deaths in care homes were around 2.3 times the number expected in this period.

# 8. Comorbidities

## 8.1 Main messages

Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.

Diabetes was mentioned on 21% of death certificates where COVID-19 was also mentioned. This finding is consistent with other studies that have noticed a higher risk of death from COVID-19 among patients with diabetes. By age, the percentage was highest in males aged 60 to 69, was higher in all BAME groups than the White group and was 43% in the Asian group and 45% in the Black group. The same inequalities were seen for hypertensive disease.
Several studies, although measuring the different outcomes from COVID-19, report an increased risk of adverse outcomes in obese or morbidly obese people.

PHE is seeking to obtain and link additional datasets that measure body mass index (BMI), a more comprehensive range of comorbidities and other sociodemographic characteristics such as ethnicity to understand the combination of these risks further.

## 8.2 Introduction

People with underlying health conditions or other recognised risk factors for severe outcomes from respiratory infections appear to be at a higher risk of poor outcomes from COVID-19 than people without these conditions. One review suggested the most commonly reported conditions associated with poor outcomes were diabetes mellitus, chronic lung disease and cardiovascular disease (40). Persons with certain underlying conditions are classed as ‘extremely clinically vulnerable’ or ‘clinically vulnerable’ to COVID-19 (41).

Emerging evidence has established a need to better understand the association between obesity and COVID-19 particularly as 28% of adults in England in 2018 were obese (Body Mass Index (BMI) of 30kg/$m^2$ or more) and 3% were morbidly obese (BMI of 40kg/$m^2$ or more) as indicated by the Health Survey for England (42). In addition, patients living with obesity may not be equally exposed to COVID-19 or may have other underlying conditions, such as those mentioned above, which influence their outcome from COVID-19.

The prevalence of obesity and underlying health conditions such as diabetes also varies by ethnic group. Data from the National Diabetes Audit suggests that type II diabetes

prevalence is higher in people from BAME communities (25). The latest data from the Health Survey for England indicates that obesity prevalence rises to 54% in Black females but was as low as 16% in Asian males (42).

However, there are limitations in the availability of appropriately linked data to understand the relationship between obesity, underlying health conditions, socioeconomic characteristics including ethnicity and risk of adverse outcomes from COVID-19. For example, some datasets are limited to inpatient data or patients admitted to ICU, so they will not include all cases or deaths from COVID-19. This section summarises the available data to date.

## 8.3 Obesity

The latest report from the Intensive Care National Audit and Research Centre (ICNARC) used data up to 21 May 2020 and showed that 7.7% of patients critically ill in intensive care units (ICU) with confirmed COVID-19 were morbidly obese compared with 2.9% of the general population (after adjusting for age and sex) (2). This disparity was also seen when looking at white and non-white patients separately.

The report also showed a relationship between BMI and death from COVID-19 in BMI over 30 kg/m$^2$. This analysis controlled for other demographics and health conditions but is restricted to those patients admitted to ICU from 289 participating trusts.

A study using data from over 400,000 patients aged 40 to 69 from UK Biobank linked to COVID-19 test data from PHE found that higher BMI was associated with a positive COVID-19 diagnosis (43). Compared with non-overweight people (BMI < 25 kg/m$^2$), the odds ratios[1] were 1.26 (confidence interval of 1.01-1.56) for those who were overweight, 1.37 (1.06-1.76) for those in obese class I and 2.04 (1.50-2.77) for those in obese classes II and III combined[2].

A study by the OpenSAFELY collaborative used a dataset of 17 million adult primary care electronic health records linked to deaths data from the COVID-19 Patient Notification System (CPNS) up to 25 April 2020 (44). This found a relationship between death from covid-19 and BMI when controlling for demographics and other health

[1] The odds of an event occurring is the probability of an event occurring divided by the probability of an event not occurring.
The odds ratio is the odds of one event occurring divided by the odds of another event occurring.
In this case, the odds ratio divides the odds of a person having covid-19 in a particular overweight or obese BMI group by the odds of a patient having covid-19 in the control group which is those people who were not overweight (BMI < 25 kg/m$^2$).
[2] Overweight is 25-29.9 kg/m$^2$, obese class I is 30-34.9 kg/m$^2$, obese class II is 35-39.9kg/m$^2$ and obese class III is 40 kg/m$^2$ or more and is also sometimes referred to as being morbidly obese.

conditions. The hazard ratio[3] compared to those who were not obese increased as BMI increased and was 1.27 (1.18-1.36) for those in obese class I, 1.56 (1.41-1.73) for those in obese class II and 2.27 (1.99 to 2.58) for those in obese class III (morbidly obese).

Although measuring the different outcomes of dying from COVID-19 once in ICU, contracting COVID-19 and dying from COVID-19, all three studies have shown a relationship between COVID-19 and increasing BMI. Of the studies mentioned, the study by the OpenSAFELY collaborative covers the broadest cohort of patients.

These findings are also consistent with studies from other countries. A study based on 383 COVID-19 patients admitted to the Third People's Hospital of Shenzhen in China found that obesity, especially in men, significantly increases the risk of developing severe pneumonia in COVID-19 patients (45). In France, a study of 124 patients admitted to intensive care in a hospital in Lille found the proportion of patients who required invasive mechanical ventilation increased with increasing BMI category (46).

NHS England have also looked at the relationship between BMI and diabetes and the risk of death from COVID-19 (47). The study linked data from the National Diabetes Audit, Hospital Episode Statistics and deaths from COVID-19 for around 265,000 people with type I diabetes and 2.9m people with type II diabetes. The analysis adjusted for demographics and other health conditions and showed the hazard ratio was highest for those with low and high BMI. For those with a BMI < 20 kg/m$^2$, the hazard ratio was 2.11 (1.32-3.38) for type I diabetes and 2.26 (2.04-2.50) for type II, and for those who were morbidly obese it was 2.15 (1.37-3.36) for type I and 1.64 (1.50-1.79) for type II.

## 8.4 Other conditions mentioned on death certificates

This section examines other conditions which have been mentioned on death certificates where COVID-19 is mentioned. The conditions included relate to people who are classed as 'clinically vulnerable' (41). Dementia has also been analysed since it is the leading cause of death among older people in England.

As this section only looks at death certificates, it will be an underestimate of the number of people who die from COVID-19 who have underlying health conditions as not all will be mentioned on the certificate.

[3] The hazard ratio is a comparison between the probability of events in a treatment group, compared to the probability of events in a control group.
In this case, it is a comparison of the probability of dying from covid-19 for people in a particular obese BMI group compared to the probability of dying for people who were not obese (BMI < 30 kg/m$^2$)

All of the conditions examined were more likely to be mentioned on a death certificate when COVID-19 was also mentioned, than they were for deaths overall. However, for cardiovascular disease, the difference was very small (Table 8.1).

The largest difference was for diabetes, which includes type I and type II. Diabetes was mentioned on 15% of all death certificates between 21 March and 1 May. However, it was mentioned on 21% of death certificates where COVID-19 was also mentioned.

Data from NHS England suggests that 26% of those who died in hospital and have tested positive for COVID-19 up to 19 May 2020 had diabetes as a pre-existing condition (48). A study using data from the National Diabetes Audit reports that death rates in those with diabetes have doubled during the pandemic (47).

**Table 8.1**. Percentage of all deaths, and percentage of COVID-19 deaths where one of the conditions were mentioned, 21 March to 1 May 2020, England. Source: Public Health England analysis of ONS death registration data.

| Condition | Percentage of all deaths where condition is mentioned | Percentage of COVID-19 deaths where condition is mentioned |
|---|---|---|
| Cardiovascular disease | 44.1 | 44.5 |
| Diabetes | 14.6 | 21.1 |
| Hypertensive diseases | 14.5 | 19.6 |
| Chronic Kidney Disease | 8.5 | 10.8 |
| Chronic Obstructive Pulmonary Disease | 10.6 | 11.5 |
| Dementia | 23.8 | 25.7 |

More detailed breakdowns of the data for each of the conditions can be found in Table 8a, 8b and 8c in the data pack.

## Diabetes

The proportion of COVID-19 deaths where diabetes is also mentioned was higher among males than females (24% compared with 18%), and by age was highest among males aged 60 to 69 (31%).

Diabetes was more likely to be mentioned on the death certificate in more deprived areas. In the most deprived areas, 26% of COVID-19 deaths also mentioned diabetes. This is significantly higher than in the least deprived areas (16%) (Figure 8.1). The proportion of COVID-19 deaths where diabetes is mentioned ranged from 18% in the White ethnic group, 43% in the Asian group to 45% in the Black group.

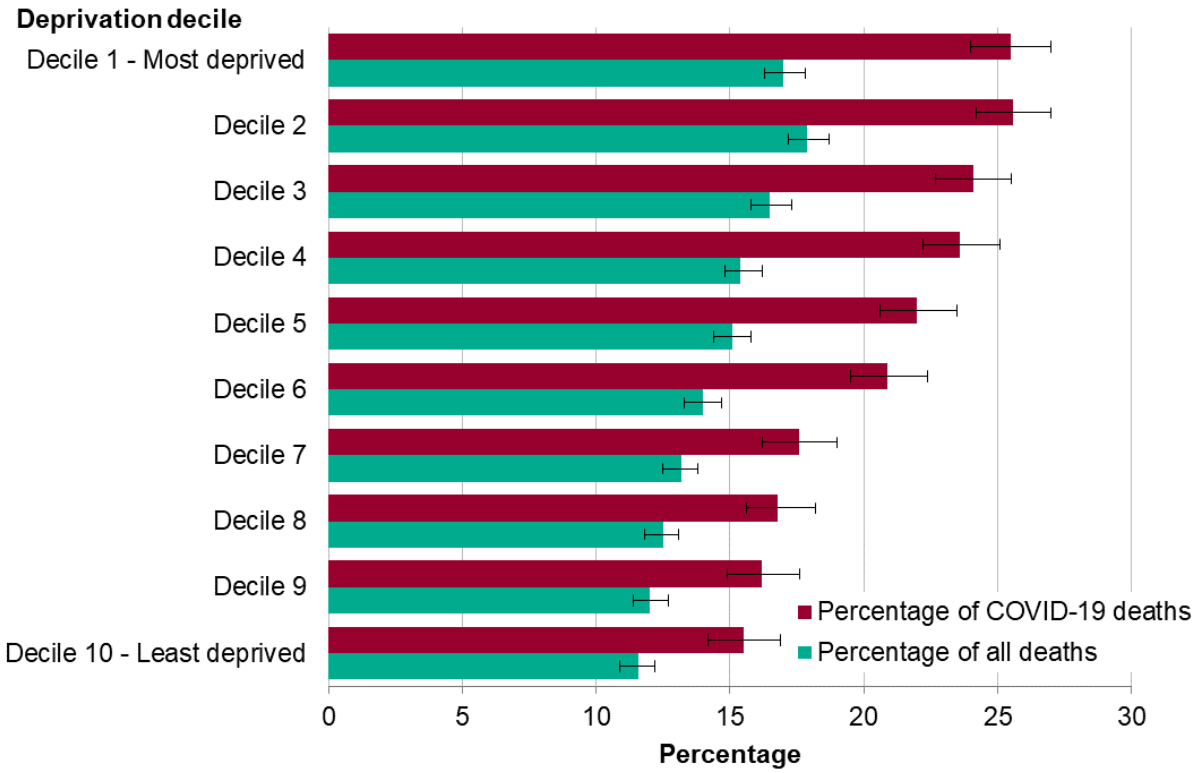



**Figure 8.1**. Percentage of COVID-19 deaths where diabetes was also mentioned on the death certificate, by deprivation decile, 21 March and 1 May 2020, England. Source: Public Health England analysis of ONS death registration data.

## Hypertensive disease

The proportion of COVID-19 deaths where hypertensive disease is also mentioned is higher among males than females (21% compared with 18%), and by age highest among males aged 60 to 69 (26%). The proportion of COVID-19 deaths where hypertensive disease is mentioned ranged from 17% in the White ethnic group to 40% in the Black group but is also high in the Asian and Mixed groups (Figure 8.2).

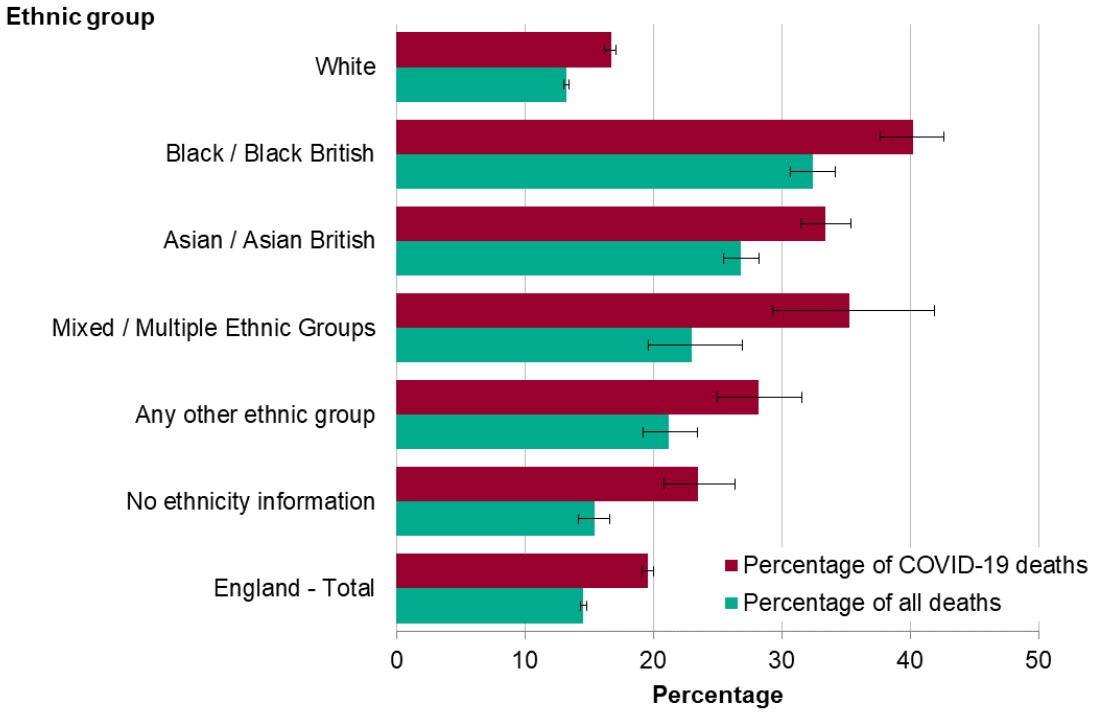



**Figure 8.2**. Percentage of COVID-19 deaths where hypertensive disease was also mentioned on the death certificate, by broad ethnic group, 21 March to 1 May 2020, England. Source: Public Health England analysis of ONS death registration data

# 9. Limitations

The analyses presented in this review use data available to PHE through multiple surveillance systems. These analyses are mostly descriptive and compare disparities in diagnosis and death from COVID-19 across a range of data sources. The descriptive nature of the analysis therefore limits the conclusions that can be drawn about the reasons for the disparities shown. In addition, there are other important limitations that must be considered when interpreting their findings.

Laboratory confirmed cases analysed in this report refer to Pillar 1 testing only. The majority of testing under this pillar has been offered to those in hospital with a medical need as well as NHS key workers, rather than the general population. Confirmed cases therefore represent the population of people with severe disease only, rather than all of those who get infected. This has important implications when considering, for example, the proportion of deaths among confirmed cases, which will be high as confirmed cases are mostly people with severe disease.

In addition, the numbers of cases and diagnosis rates are likely to be strongly influenced by case definition and testing policy, both of which have changed since the first cases were identified, may vary between geographical areas, and must be interpreted under that light. For example, when case definition included travel history, this may have made it more likely to test people of specific ethnic groups.

As of 19 May, 42 trusts had reported lower level of care patients (defined as admission to any hospital ward, excluding ICU or HDU), and 94 trusts contributed ICU/HDU (critical care) patient data to the COVID-19 Hospitalisation in England Surveillance System (CHESS).

Reporting to CHESS varies by trusts and the majority of trusts in London do not consistently report which will impact on the representativeness of the hospitalised cases. To account for variation in Trusts reporting within regions (and batch reporting), rather than providing daily number of hospitalised patients by region, daily rates are reported as 3 days moving averages using only the reporting trusts' catchment area populations (rather than regional population denominator). The demographic data presented here has not been adjusted for Trust underreporting as we cannot confidently assume and impute the missing demographic profiles of hospitalised patients for Trusts who have not reported. Because demographic composition of the population is considerably different in London from the rest of the country, the hospitalisation data must be interpreted with caution. Further analyses of the CHESS dataset have not been presented in this report because of its current limitations.

The analyses of ONS mortality data are based on records which have been provided to PHE very shortly after they have been registered. These records will have passed a series of automatic validation processes but will not have been subject to all the procedures which ONS undertake to ensure the quality and completeness of mortality data. These data are therefore provisional and small changes will be likely after data have been finalised. However, these changes are unlikely to affect the conclusions drawn from the data.

Ethnicity information for cases and deaths was derived through linkage to hospital records. Ethnicity information for the population denominators used to calculate the rates was derived from the 2011 Census. This creates a mismatch between the two sources and it is possible that there are proportionally more people assigned to the Other ethnic group in the hospital data than there are in the census data. This may explain the high diagnosis and mortality rates in the Other group, which requires further investigation and no firm conclusions can be drawn about this group.

However, this mismatch described above will not be apparent in the survival analysis presented as population denominators are not used for that analysis. In addition, it should not affect the comparisons of inequality with data for previous years as data for all time periods will be subject to a similar bias.

It was not possible to obtain ethnicity information for some records, although the proportion with missing ethnicity was low for most data sources (see data and methods section). CHESS data had the largest percentage with missing ethnicity data, particularly for ICU data, and therefore these findings should be given less weight. People with missing ethnicity data have been excluded from the analysis by ethnic group. This may have introduced some bias by excluding people who are less likely to have a hospital record or ethnicity recorded in their records.

The linked datasets used do not currently include all data that would be useful to understand disparities across all groups. They don’t include, for example, information about household composition or genetic factors, which may explain some of the findings.

Information on vulnerable groups is lacking. Very few surveillance systems accurately capture groups of the population who are known to have the poorest health outcomes such as vulnerable migrants, sex workers or people experiencing homelessness or rough sleeping. These analyses therefore do not allow us to accurately assess the impact of COVID-19 on the most vulnerable groups of the population.

Occupational data is not currently available for all diagnosed cases. Robust data are available for those who have died and have been included in this report. Analysis of diagnosed cases has currently only been undertaken for nurses, midwives and nursing

assistants registered with the NMC. This data will continue to be analysed and further work of other healthcare workers is being planned.

The analysis of comorbidities presented in this report is currently limited to an analysis of death certificates and other published sources of data on obesity. Very few datasets available for analysis by PHE contain information on height and weight to calculate BMI and link to diagnosed cases and deaths.

A more thorough analysis is required to fully understand the relationships between comorbidities including obesity, sociodemographic characteristics such as ethnicity and occupation and the risk of diagnosis and death to understand these disparities further.

Comparisons have been made against the most appropriate baseline or group available at the time of analysis. This has created some complexities in interpretation and it may be possible to improve this when other data become available.

Some of the papers referenced in this report are early publication papers and have not been peer reviewed and should therefore be interpreted with some caution. However, many are authored by academics from multiple institutions which may give more confidence in the approach taken and conclusions drawn.

# 10. Data sources and methodologies

## 10.1 Testing and laboratory confirmed cases

Respiratory Datamart and the Second Generation Surveillance System (SGSS) were used for information about all samples tested and their results (positive and negative) from public health, NHS and private laboratories that report to PHE.

SGSS is an application that stores and manages data on laboratory isolates and notifications and is the preferred method for capturing routine laboratory surveillance data on infectious diseases and antimicrobial resistance from laboratories across England. Respiratory datamart is a laboratory-based surveillance system for influenza and other respiratory viruses in England.

The same individual can receive multiple tests. These were deduplicated so that a laboratory confirmed case of COVID-19 is any individual who has received a positive test result for the SARS-CoV-2 virus.

The majority of testing to date has been offered to those in hospital with a medical need. Laboratory confirmed cases therefore are likely to represent the typical population of people with severe disease, rather than all of those who get infected.

## 10.2 Hospitalised cases

New patients admitted to hospital with COVID-19 are reported daily to the COVID-19 Hospitalisations in England surveillance system (CHESS) by acute NHS trusts in England through a secure web portal. There are two subsets of data within CHESS: COVID-19 cases admitted to a lower level of care (defined as admission to any hospital ward, excluding ICU or HDU); COVID-19 cases admitted to ICU/HDU (critical care). Trusts report aggregate numbers by age group of all new hospital admissions with COVID-19 or acute respiratory illness. All acute trusts are asked to report individual level data on all new ICU/HDU admissions with COVID-19 and a sentinel network of Trusts report individual level data on all new hospital admissions at any level of care. All data are cleaned and analysed daily.

Reporting varies by trusts and not all trusts report daily; as of 19 of May, 42 trusts had reported lower level of care, and 94 trusts contributed critical care patient data to CHESS. The majority of trusts in London do not consistently report to CHESS which will impact on the representativeness of the demographic profile of hospitalised cases, including those in critical care.

Checking the validity of CHESS aggregate data has been done by comparing CHESS data with NHS England data for fields common to both datasets where trusts did report to both systems and there is good agreement via scatter plot and Bland–Altman plots. Nevertheless, further analyses of the CHESS dataset have not been presented in this report because of its current limitations.

## 10.3 Mortality

Public Health England receives reports of death from 3 sources:

- NHS England (NHSE) line listing of deaths reported by NHS trusts in the COVID-19 Patient Notification System (CPNS);
- Health protection teams (HPTs) reporting deaths notified to them (primarily non-hospital settings);
- The Demographic Batch Service (DBS) traced data, which takes a complete record level list of all individuals with a positive test in SGSS and links that to the central NHS Digital patient record of all deaths.

Data from each source are merged and duplicates removed in order to retain only one record per individual. Cleaned data sets are sent to DBS for tracing of missing information and then merged to form the final dataset.

This dataset only includes deaths in which the deceased has had a positive test result. More detail about the PHE data series on deaths in people with COVID-19 is available here: https://www.gov.uk/government/publications/phe-data-series-on-deaths-in-people-with-covid-19-technical-summary.

## 10.4 ONS registered deaths

Death registration data supplied by the Office for National Statistics over the period 24 March to 8 May 2020 was obtained and used for this analysis.

## 10.5 Data linkage to assign ethnicity

Completeness of ethnicity recording in the above datasets is low; this is common among similar systems. To mitigate this, data was linked with Hospital Episode Statistics (HES) data to assign ethnicity information. HES is a database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England. HES use ethnic categories as classified by the 2001 ONS census (49).

Ethnicity was assigned to all datasets by linking, using NHS number and date of birth, to the latest recording of ethnicity in the Outpatient Hospital Episode Statistics (HES) or the HES Admitted Patient Care data set.

Records that could not be linked to HES, either because there was not a record to link to within HES or because information on date of birth and/or NHS number was inconsistent or missing, were excluded from the ethnicity analyses in this report. People from certain ethnic backgrounds may be less likely to have an NHS number or full date of birth than those from other ethnic groups and consideration needs to be given to this in the interpretation of the findings within this report.

It was possible to obtain ethnicity for:

- 91.9% of COVID-19 cases
- 89.5% of cases in the lower level of care subset and 80.9% of cases in the ICU subset (for hospitalised cases)
- 99.4% of the deaths in laboratory confirmed COVID-19 patients
- 97% of all cause deaths

For the excess mortality model any unknown or not stated ethnicities were imputed using direct imputation methodology.

## 10.6 Population data

The denominators used to calculate rates by ethnic group are from the ONS 2018 mid-year populations for England, which uses the Harmonised Classification of Ethnic Groups. For ethnicity categories to match between HES and ONS denominators, the following were merged:

- in ONS data, the “Gypsy or Irish Traveller” category was merged into “Any other White background”
- in HES data, the “Chinese” category was moved to the “Asian or Asian British” grouping
- in both datasets, the “Arab” category was included in “Any Other Ethnic Group”

Appendix B provides a comparison of the ONS and HES ethnic categories.

ONS 2019 mid-year populations for Government Office Regions were used for population denominators by region and Upper Tier Local Authority (UTLA). ONS 2018 population estimates by LSOA were grouped into deprivation quintiles and deciles and used for population denominators.

## 10.7 Assigning deprivation quintiles and deciles

Deprivation quintiles and deciles have been constructed using Index of Multiple Deprivation scores at lower super output area (LSOA) level. LSOAs are small geographic areas produced by ONS to enable reporting of small area statistics in England and Wales. There are 32,844 LSOAs in England, each having a population of approximately 1,500.

LSOAs within England were ranked from most to least deprived and then divided into ten categories (deciles) or five categories (quintiles) with approximately equal numbers of LSOAs in each. The deprivation index used was the Index of Multiple Deprivation 2019 (IMD2019) scores from the English Indices of Deprivation 2019, released by the Ministry of Housing, Communities & Local Government (13).

## 10.8 Age standardisation

Age-standardised rates adjust for differences in the age structure of populations and allow comparisons to be made between geographical areas and through time, allowing identification of any underlying change in mortality rates. The direct method uses the age-standardised rate for a particular condition which would have occurred if the observed age-specific rates for the condition had applied in a given standard population. The standard used throughout this report is the European Standard Population 2013. Death rates calculated using ONS registered deaths were annualised to enable comparisons with previous years and with ONS analysis.

## 10.9 Cox regression

COVID-19 laboratory confirmed cases were matched to reported deaths by NHS number. Records that contained the linking field were included in the final analysis dataset (n = 130,101 cases, n = 28,246 deaths). Cox proportional hazards regression models were used (presented in Appendix A) to model survival time between date of positive specimen and date of death or survival to 13 May 2020 among people with confirmed COVID-19 by age, sex, ethnicity, region and deprivation (IMD quintile). Interaction between variables was assessed; since there are interactions between age and some of the other variables, models were stratified by age in sub-models: an all ages model, one for working age patients (20-64 years of age) and one for older patients (65+ years of age). All three models included all variables. The proportional hazards assumption was tested using Schoenfeld residuals and only sex was significant. However, sex was not adjusted for as a time varying covariate due to the nature of the stability of this factor. Hazard ratios from the crude and fully adjusted models are shown in Appendix A with 95% confidence intervals.

## 10.10 Nurses, midwives and nursing assistants

The data referring to the cases and deaths among Nurses and Midwives used the Nursing and Midwifery Council (NMC) register data of currently eligible to work nurses, midwives and nursing associates. The register data does not include temporary registrants who may have re-joined the temporary register recently to work in the COVID-19 response.

The NMC register was obtained on 14 May. This was linked to laboratory confirmed cases of COVID-19 as of 19 May. Linking was done using surname, first name, sex, date of birth and postcode. The linking process excluded cases for which information did not match, which means it will not identify some professionals.

A match with a confirmed COVID-19 case and being on the NMC register does not imply that the infection was acquired occupationally.

## 10.11 People with no fixed abode

The data for homelessness are based on the no fixed abode (NFA) code through the residential address ascribed in SGSS. NFA codes are subject to underreporting or misclassification, as well as changes in reporting over time.

Population (denominator) figures to calculate rates are based on estimates of the number of people sleeping rough in England in autumn 2019 (50). People sleeping rough are defined as “People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or ‘bashes’ which are makeshift shelters, often comprised of cardboard boxes)”. These figures are subject to some uncertainty and should be treated as estimates of the number of people sleeping rough on a single night and an indication of trends over time.

## 10.12 Excess mortality model

### Excess deaths

Total cumulative excess mortality is estimated by calculating the cumulative deaths between March 20 and 7 May 2020 and subtracting the expected cumulative deaths in this period. Expected deaths are modelled using the previous five years of data, except when modelling for ethnicity, where the period 2014 to 2018 was used.

ONS compared deaths in 2020 with the simple average for the years 2015 to 2019. However, this will not adjust for ageing of the population or the effect of Easter or bank holidays on the number of deaths registered. The PHE model does adjust for this.

## Daily registered deaths

We present daily ONS registered deaths from March 20 to 7 May 2020. To maximise correspondence with the pattern of death registrations in the baseline data (expected deaths), all weekend and public holiday death registrations were reassigned to the nearest working day.

## Modelled expected deaths

Models to develop baseline estimates of the expected number of deaths on a given working day of the year were constructed using a combination of deaths and population-denominator data from 2015 to 2019. Because historically deaths were registered on working days, the few deaths registered on weekends or bank holidays were assigned to the nearest working day.

## Data structure and covariates

Independent variables included day of week, whether a day was a bank holiday, and time of year allowing for seasonal effects. The model also includes specific adjustments for registrations around bank holidays, a linear trend by year and covariates allowing for the effect of age, gender, deprivation, ethnicity and geographical region. In addition, we include an interaction term between age and sex to allow sex to modify the effect of age on death.

The model structures are hierarchical with population denominators and counts of death each being fully disaggregated to demographic sub-groups. England, and region models contain variables for age, sex, and upper tier local authority (UTLA). Ethnicity and deprivation models were built separately from the England model because, by including UTLA in these models, the datafile became too large to model. Ethnicity and deprivation models therefore each contain age, sex and region.

To avoid competing risk, for place of death analyses, each outcome (e.g. death at home) was modelled separately. These models are currently built with no demographic structure and no denominators.

## Statistical modelling

The models are Quasi-Poisson regression models, on the logarithmic scale (a ‘log link’) which account for over dispersion. The models for all causes, by age, sex, ethnicity and deprivation contained the set of covariates outlined in the section above and an offset reflecting the log-population-size in each population subset. Data were analysed using the glm function in R. In calculating the expected total number of deaths in a given population subgroup (e.g. males aged 85+ years in the Middlesbrough UTLA) on a given date in 2020, we added up the number of deaths expected in that specific subgroup taking appropriate account of the (gradually increasing) size of that sub-population size between 2015 and 2019.

## COVID-19 deaths

Among cumulative death charts we added an orange ‘ribbon’ to represent deaths with a mention of COVID-19 on the death certificate. Even though it is well recognised that many people dying of COVID-19 had other significant co-morbidities, the majority (96%) of COVID-associated deaths are recorded as having COVID as the underlying cause of death.

## Occupational classification

Mortality has been analysed according to the Standard Occupational Classification 2010 (SOC 2010) ‘minor groups’ and ‘unit groups’, the lowest level of the classification (51).

# 11. References

1. Office for National Statistics (ONS). Deaths involving COVID-19, England and Wales: deaths occurring in April 2020 [Online]. 15 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinapril2020
2. Intensive Care National Audit & Research Centre (ICNARC). ICNARC report on COVID-19 in critical care. [Online] 22 May 2020. [Cited: 23 May 2020]. Available from: https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports
3. Zhou F, Yu T, Du R, Fan G, Liu Y, Liu Z, Xiang J, Wang Y, Song B, Gu X, Guan L. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. The Lancet. 11 Mar 2020.
4. Pigoga JL, Friedman A, Broccoli M, Hirner S, Naidoo AV, Singh S, Werner K, Wallis LA. Clinical and historical features associated with severe COVID-19 infection: a systematic review. medRxiv. 2020 Jan 1.
5. Docherty AB, Harrison EM, Green CA, Hardwick HE, Pius R, Norman L, Holden KA, Read JM, Dondelinger F, Carson G, Merson L. Features of 16,749 hospitalised UK patients with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol. medRxiv, 2020.
6. Public Health England (PHE). National COVID-19 surveillance report: 14 May 2020 (week 20). National COVID-19 surveillance reports [Online]. 14 May 2020 [Cited: 15 May 2020]. Available from: https://www.gov.uk/government/publications/national-covid-19-surveillance-reports.
7. Office for National Statistics (ONS). Deaths registered weekly in England and Wales, provisional: week ending 8 May 2020 [Online]. 19 May 2020 [Cited: 23 May 2020]. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending8may2020#deaths-registered-by-place-of-occurrence.
8. Public Health England (PHE). Coronavirus (COVID-19) in the UK [Online]. 22 May 2020 [Cited: 23 May 2020]. Available from: https://coronavirus.data.gov.uk/.
9. Office for National Statistics (ONS). Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020 [Online]. 1 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april.
10. de Lusignan S, Dorward J, Correa A, Jones N, Akinyemi O, Amirthalingam G, Andrews N, Byford R, Dabrera G, Elliot A, Ellis J. Risk factors for SARS-CoV-2 among patients in the Oxford Royal College of General Practitioners Research and Surveillance Centre primary care network: a cross-sectional study. The Lancet Infectious Diseases, May 2020.

11. Bray I, Gibson A, White J. Covid-19 mortality: A multivariate ecological analysis in relation to ethnicity, population density, obesity, deprivation and pollution. Manuscript submitted for publication.
12. Patel AP, Paranjpe MD, Kathiresan NP, Rivas MA, Khera AV. Race, Socioeconomic Deprivation, and Hospitalization for COVID-19 in English participants of a National Biobank. medRxiv, 2020.
13. Ministry of Housing, Communities & Local Government (MHCLG). English indices of deprivation 2019 [Online]. 26 September 2019 [Cited: 23 May 2020]. Available from: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019.
14. Rose TC, Mason K, Pennington A, McHale P, Taylor-Robinson DC, Barr B. Inequalities in COVID19 mortality related to ethnicity and socioeconomic deprivation. medRxiv, 2020.
15. Aldridge RW, Lewer D, Katikireddi SV, Mathur R, Pathak N, Burns R, Fragaszy EB, Johnson AM, Devakumar D, Abubakar I, Hayward A. Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data. Wellcome Open Research. 2020 May 6;5(88):88
16. Office for National Statistics (ONS). Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020 [Online]. 7 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020
17. Harrison E, Docherty A, Semple C, CO-CIN. Investigating associations between ethnicity and outcome from COVID-19 [Online]. 24 April 2020 [Cited: 23 May 2020]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886433/s0238-co-cin-report-ethnicity-outcomes-250420-sage29.pdf
18. Cabinet Office (CO). Regional ethnic diversity [Online]. 11 July 2019 [Cited: 23 May 2020]. Available from: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest
19. Cabinet Office (CO). Overcrowded households [Online]. 27 April 2020 [Cited: 23 May 2020]. Available from: https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest
20. Cabinet Office (CO). People living in deprived neighbourhoods [Online]. 17 May 2019 [Cited: 23 May 2020]. Available from: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest#people-living-in-the-most-deprived-10-of-neighbourhoods-by-ethnicity
21. Office for National Statistics (ONS). Which occupations have the highest potential exposure to the coronavirus (COVID-19)? [Online]. 11 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandem

ployeetypes/articles/whichoccupationshavethehighestpotentialexposuretothecoronaviruscovid19/2020-05-11
22. Cabinet Office (CO). People born outside the UK [Online]. 19 March 2020 [Cited: 23 May 2020]. Available from: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-born-outside-the-uk/latest
23. Kuppuswamy CV, Gupta S. Excess coronary heart disease in South Asians in the United Kingdom. BMJ 2005;330:1223
24. Chaturvedi N, McKeigue PM, Marmot MG. Resting and ambulatory blood pressure differences in Afro-Caribbeans and Europeans. 2003, Hypertension, Vol. 22(1).
25. NHS Digital. National Diabetes Audit Report 1 - Care Processes and Treatment Targets 2018-19, Short Report [Online]. 13 December 2019 [Cited: 27 May 2020]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/national-diabetes-audit/report-1--care-processes-and-treatment-targets-2018-19-short-report
26. D, Koh. Occupational risks for COVID-19 infection. Occupational medicine (Oxford, England). 2020 Mar;70(1):3.
27. European Centre for Disease Prevention and Control (ECDC). Rapid risk assessment: Coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA and the UK – eighth update [Online]. 8 April 2020 [Cited: 23 May 2020]. Available from: https://www.ecdc.europa.eu/en/publications-data/rapid-risk-assessment-coronavirus-disease-2019-covid-19-pandemic-eighth-update
28. Cook T, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from covid-19 analysed. Health Service Journal. 2020 Apr 22;22.
29. Office for National Statistics (ONS). Coronavirus (COVID-19) Infection Survey pilot: England, 21 May 2020 [Online]. 21 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/england21may2020
30. Campos-Matos I, Stannard J, de Sousa E, O'Connor R, Newton JN. From health for all to leaving no-one behind: public health agencies, inclusion health, and health inequalities. The Lancet Public Health. 2019 Dec 1;4(12):e601-3
31. Aldridge RW, Story A, Hwang SW, Nordentoft M, Luchenski SA, Hartwell G, Tweed EJ, Lewer D, Katikireddi SV, Hayward AC. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. The Lancet. 2018 Jan 20;391(10117):241-50
32. Luchenski S, Maguire N, Aldridge RW, Hayward A, Story A, Perri P, Withers J, Clint S, Fitzpatrick S, Hewett N. What works in inclusion health: overview of effective interventions for marginalised and excluded populations. The Lancet. 2018 Jan 20;391(10117):266-80
33. COVID-19 and homelessness in England: a modelling study of the COVID-19 pandemic among people experiencing homelessness, and the impact of a residential intervention to isolate vulnerable people and care for people with symptoms. Lewer D, Braithwaite I, Bullock M, Eyre MT, Aldridge RW. s.l. : medRxiv. 2020.

34. Tobolowsky FA, Gonzales E, Self JL, Rao CY, Keating R, Marx GE, McMichael TM, Lukoff MD, Duchin JS, Huster K, Rauch J. COVID-19 outbreak among three affiliated homeless service sites—King County, Washington, 2020. Morbidity and Mortality Weekly Report. 2020 May 1;69(17):523
35. H, Leung. Why Singapore, Once a Model for Coronavirus Response, Lost Control of Its Outbreak. Time Magazine [Online]. 20 April 2020 [Cited: 25 May 2020]. Available from: https://time.com/5824039/singapore-outbreak-migrant-workers/
36. Public Health England (PHE). COVID-19: number of outbreaks in care homes – management information [Online]. 21 May 2020 [Cited: 23 May 2020]. Available from: https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information
37. Comas-Herrera A, Zalakain J, Litwin C, Hsu AT, Lane N, Fernández JL. Mortality associated with COVID-19 outbreaks in care homes: early international evidence. International Long-Term Care Policy Network, CPEC-LSE. 2020 Apr 12;3
38. Office for National Statistics (ONS). Number of deaths in care homes notified to the Care Quality Commission, England [Online]. 19 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/numberofdeathsincarehomesnotifiedtothecarequalitycommissionengland
39. Office for National Statistics (ONS). Deaths registered weekly in England and Wales, provisional: week ending 15 May 2020 [Online]. 26 May 2020 [Cited: 27 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending15may2020
40. National Health Library and Knowledge Service (Ireland). Summary of Evidence: COVID-19 [Online]. 28 April 2020 [Cited: 18 May 2020]. Available from: https://hselibrary.ie/covid-19-evidence-sources-and-summaries/
41. NHS England. Who's at higher risk from coronavirus [Online]. 2020 [Cited: 23 May 2020]. Available from: https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk-from-coronavirus/whos-at-higher-risk-from-coronavirus/
42. NHS Digital. Health Survey for England 2018: Data tables [Online]. 28 November 2019 [Cited: 23 May 2020]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018/health-survey-for-england-2018-data-tables
43. Khawaja AP, Warwick AN, Hysi PG, Kastner A, Dick A, Khaw PT, Tufail A, Foster PJ, Khaw KT. Associations with covid-19 hospitalisation amongst 406,793 adults: the UK Biobank prospective cohort study. medRxiv, 2020
44. Williamson E, Walker AJ, Bhaskaran KJ, Bacon S, Bates C, Morton CE, Curtis HJ, Mehrkar A, Evans D, Inglesby P, Cockburn J. OpenSAFELY: factors associated with COVID-19-related hospital death in the linked electronic health records of 17 million adult NHS patients. medRxiv, 2020

45. Qingxian C, Fengjuan C, Fang L, Xiaohui L, Tao W, Qikai W, Qing H, Zhaoqin W, Yingxia L, Jun C, Lei L. Obesity and COVID-19 severity in a designated hospital in Shenzhen, China. The Lancet, 2020
46. Simonnet A, Chetboun M, Poissy J, Raverdy V, Noulette J, Duhamel A, Labreuche J, Mathieu D, Pattou F, Jourdain M, Lille Intensive Care COVID-19 and Obesity study group. High prevalence of obesity in severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) requiring invasive mechanical ventilation. Obesity. 9 Apr 2020
47. Holman N, Knighton P, Kar P, O'Keefe J, Curley M, Weaver A, Barron E, Bakhai C, Khunti K, Wareham N, Sattar N, Young B, Valabhji J. Type 1 and Type 2 diabetes and COVID-19 related mortality in England: a cohort study in people with diabetes. NHS England, 2020
48. NHS England. COVID-19 Daily Deaths [Online]. 2020 [Cited: 23 May 2020]. Available from: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-daily-deaths/
49. Office for National Statistics (ONS). Research report on population estimates by ethnic group and religion [Online]. [Cited: 29 04 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/researchreportonpopulationestimatesbyethnicgroupandreligion/2019-12-04.
50. Ministry of Housing, Communities and Local Government (MHCLG). Rough sleeping snapshot in England: autumn 2019 [Online]. 27 February 2020 [Cited: 23 May 2020]. Available from: https://www.gov.uk/government/publications/rough-sleeping-snapshot-in-england-autumn-2019/rough-sleeping-snapshot-in-england-autumn-2019
51. Office for National Statistics (ONS). SOC2010 volume 1: structure and descriptions of unit groups [Online]. 8 March 2016 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/methodology/classificationsandstandards/standardoccupationalclassificationsoc/soc2010/soc2010volume1structureanddescriptionsofunitgroups
52. Office for National Statistics (ONS). Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020 [Online]. 11 May 2020 [Cited: 23 May 2020]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/latest
53. Public Health England (PHE). Palliative and End of Life Care Profiles [Online]. 2020 [Cited: 23 May 2020]. Available from: https://fingertips.phe.org.uk/profile/end-of-life
54. Public Health England (PHE). Public Health Outcomes Framework – Overarching Indicators. Technical User Guide [Online]. February 2018 [Cited: 23 May 2020]. Available from: https://fingertips.phe.org.uk/documents/PHOF_Overarching_user_guide_Feb_2018_updated%20FINAL.pdf

# Appendices

## Appendix A: Multivariate analyses

COVID-19 laboratory confirmed cases were matched to reported deaths by NHS number. Records that contained the linking field were included in the final analysis dataset (n = 130,101 cases, n = 28,246 deaths). Missing data excluded from regression: sex, n=10; age group, n=38; ethnic group, n=2,024; region, n=446; deprivation quintile, n=639.

Cox proportional hazards regression models were used to model survival time between date of positive specimen and date of death or survival to 13 May 2020 among people with confirmed COVID-19 by age, sex, ethnicity, region and deprivation (IMD quintile). Interaction between variables was assessed; since there are interactions between age and some of the other variables, models were stratified by age in sub-models: an all ages model, one for working age patients (20-64 years of age) and one for older patients (65+ years of age). All three models included all variables. The proportional hazards assumption was tested using Schoenfeld residuals and only sex was significant. However, sex was not adjusted for as a time varying covariate due to the nature of the stability of this factor. Hazard ratios from the crude and fully adjusted models are shown in Appendix A with 95% confidence intervals.

In all three models, men had a significantly higher probability of death compared to women (adjusted hazard ratio (aHR)=1.54 (95%CI 1.50-1.57)) (Table A1). The increased risk was higher for working age adults (aHR=1.99 (95%CI 1.85-2.14)) than for older adults (aHR=1.47 (95%CI=1.44-1.51)).

Compared to the youngest age group of patients (<20), the probability of death significantly increased with age up to approximately 70-fold for those aged 80 and over (aHR=70.26 (95%CI 43.66-113.07)).

Those living in the most deprived areas had a higher probability of death when compared to those living in the least deprived (aHR for the most deprived quintile was 1.16 (95%CI 1.12-1.21) when compared to the least deprived quintile (Table A1). The risk was higher for working age patients (aHR=1.93 (95%CI 1.70-2.19)) (Annex A, Table A2) than for older patients (aHR=1.09 (95%CI 1.04-1.13)) (Table A3).

Regional differences were observed, with probability of death being higher as compared to London in East of England (aHR=1.10 (95%CI 1.05 - 1.15)) and lower as compared to London in North East (aHR=0.82 (95%CI 0.77 - 0.87)), North West (aHR=0.92

(95%CI 0.88 - 0.96)), South East (aHR=0.92 (95%CI 0.88 - 0.96)), South West (aHR=0.89 (95%CI 0.84 - 0.94)), West Midlands (aHR=0.93 (95%CI 0.89 - 0.98)) and Yorkshire and Humber (aHR=0.92 (95%CI 0.88 - 0.97)). The increased probability in East of England compared to London was observed in older age groups only (Table A3), whereas the lower probability in other regions as compared to London was primarily observed in the working age group (Table A2).

Six ethnic groups had significantly higher probability of death when compared to White British ethnicity in the model with all ages: Bangladeshi (aHR=2.02 (95% CI 1.74-2.35)), Pakistani (aHR=1.44 (95% CI 1.31-1.58), other Black (aHR=1.35 (95% CI 1.18-1.55), Chinese (aHR=1.28 (95%CI 1.04-1.58), Indian (aHR=1.22 (95% CI 1.13-1.32), other Asian (aHR=1.13 (95% CI 1.02-1.25)) and Black Caribbean (aHR=1.10 (95% CI 1.02-1.19) (Table A1). People of White Irish ethnicity had lower probability of death when compared to White British ethnicity (aHR=0.88 (95% CI 0.79-0.99)).

These results were replicated in both age groups for people of Bangladeshi, Pakistani, Black Caribbean and Black other ethnic groups. For older age groups, the probability of death was also higher among people of Chinese, Indian and Other Asian ethnic groups (Tables A2 and A3).

**Table A1.** Multivariable hazard ratios for death among those with laboratory confirmed COVID-19. Data up to 13 May, England. Source: Public Health England Second Generation Surveillance System.

| | | | Univariable | | | Multivariable | | |
|---|---|---|---|---|---|---|---|---|
| | **number died** | **number total** | **HR** | **95% CI** | **p-value** | **aHR** | **95% CI** | **p-value** |
| **Sex** | | | | | | | | |
| Female | 11,470 | 69,558 | 1.00 (ref) | | | 1.00 (ref) | | |
| Male | 16,776 | 60,533 | 1.74 | (1.69-1.78) | <0.001 | 1.54 | (1.50 - 1.57) | <0.001 |
| **Age group** | | | | | | | | |
| <20 | 19 | 2,004 | 1.00 (ref) | | | 1.00 (ref) | | |
| 20-39 | 190 | 22,267 | 0.89 | (0.54-1.47) | 0.65 | 0.97 | (0.59 - 1.59) | 0.90 |
| 40-49 | 455 | 15,349 | 3.20 | (1.97-5.20) | <0.001 | 3.27 | (2.01 - 5.31) | <0.001 |
| 50-59 | 1,507 | 19,217 | 8.98 | (5.57-14.49) | <0.001 | 9.03 | (5.60 - 14.56) | <0.001 |
| 60-69 | 3,226 | 15,002 | 26.77 | (16.62-43.12) | <0.001 | 25.50 | (15.83 - 41.08) | <0.001 |
| 70-79 | 6,937 | 19,060 | 51.42 | (31.95-82.77) | <0.001 | 50.18 | (31.17 - 80.79) | <0.001 |
| 80+ | 15,912 | 37,164 | 66.92 | (41.59-107.68) | <0.001 | 70.26 | (43.66 - 113.07) | <0.001 |
| **Ethnic group** | | | | | | | | |
| White - British | 22,880 | 99,098 | 1.00 (ref) | | | 1.00 (ref) | | |
| Asian / Asian British - Bangladeshi | 182 | 708 | 1.10 | (0.95-1.27) | 0.21 | 2.02 | (1.74 - 2.35) | <0.001 |
| Asian / Asian British - Chinese | 92 | 470 | 0.78 | (0.64-0.96) | 0.02 | 1.28 | (1.04 - 1.58) | 0.02 |
| Asian / Asian British - Indian | 746 | 4,149 | 0.75 | (0.69-0.81) | <0.001 | 1.22 | (1.13 - 1.32) | <0.001 |
| Asian / Asian British - Other | 412 | 3,233 | 0.51 | (0.46-0.56) | <0.001 | 1.13 | (1.02 - 1.25) | 0.02 |
| Asian / Asian British - Pakistani | 483 | 2,353 | 0.86 | (0.78-094) | 0.001 | 1.44 | (1.31 - 1.58) | <0.001 |
| Black / Black British - African | 430 | 3,157 | 0.53 | (0.48-0.58) | <0.001 | 1.06 | (0.96 - 1.18) | 0.24 |
| Black / Black British - Caribbean | 713 | 2,367 | 1.30 | (1.21-1.40) | <0.001 | 1.10 | (1.02 - 1.19) | 0.01 |
| Black / Black British - Other | 229 | 1,167 | 0.79 | (0.69-0.91) | <0.001 | 1.35 | (1.18 - 1.55) | <0.001 |
| Mixed - Other | 97 | 629 | 0.63 | (0.51-0.77) | <0.001 | 1.04 | (0.85 - 1.28) | 0.68 |
| Mixed - White and Asian | 30 | 285 | 0.43 | (0.30-0.61) | <0.001 | 1.20 | (0.84 - 1.72) | 0.32 |
| Mixed - White and Black African | 22 | 201 | 0.42 | (0.28-0.65) | <0.001 | 0.79 | (0.50 - 1.24) | 0.30 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Mixed - White and Black Caribbean | 46 | 248 | 0.77 | (0.57-1.02) | 0.07 | 1.18 | (0.88 - 1.57) | 0.28 |
| Other - Any other ethnic group | 574 | 3,725 | 0.62 | (0.57-0.67) | <0.001 | 1.02 | (0.94 - 1.12) | 0.60 |
| White - Irish | 293 | 1,072 | 1.20 | (1.07-1.35) | 0.002 | 0.88 | (0.79 - 0.99) | 0.04 |
| White - Other | 951 | 5,215 | 0.76 | (0.71-0.81) | <0.001 | 0.98 | (0.92 - 1.05) | 0.62 |
| **Region** | | | | | | | | |
| London | 5,666 | 24,797 | 1.00 (ref) | | | 1.00 (ref) | | |
| East Midlands | 2,038 | 7,828 | 1.22 | (1.16-1.29) | <0.001 | 0.97 | (0.92 - 1.03) | 0.35 |
| East of England | 3,061 | 12,426 | 1.16 | (1.11-1.21) | <0.001 | 1.10 | (1.05 - 1.15) | <0.001 |
| North East | 1,562 | 8,987 | 0.79 | (0.74-0.83) | <0.001 | 0.82 | (0.77 - 0.87) | <0.001 |
| North West | 4,603 | 22,258 | 0.94 | (0.91-0.98) | 0.004 | 0.92 | (0.88 - 0.96) | <0.001 |
| South East | 3,667 | 19,117 | 0.85 | (0.82-0.89) | <0.001 | 0.92 | (0.88 - 0.96) | <0.001 |
| South West | 1,490 | 7,023 | 0.96 | (0.91-1.02) | 0.21 | 0.89 | (0.84 - 0.94) | <0.001 |
| West Midlands | 3,617 | 14,887 | 1.14 | (1.10-1.20) | <0.001 | 0.93 | (0.89 - 0.98) | 0.003 |
| Yorkshire and Humber | 2,492 | 12,332 | 0.94 | (0.90-0.99) | 0.01 | 0.92 | (0.88 - 0.97) | 0.002 |
| **Deprivation quintile** | | | | | | | | |
| 1 - most deprived | 6,748 | 30,040 | 1.08 | (1.04-1.13) | <0.001 | 1.16 | (1.12 - 1.21) | <0.001 |
| 2 | 6,250 | 28,724 | 1.03 | (1.00-1.07) | 0.09 | 1.10 | (1.05 - 1.14) | <0.001 |
| 3 | 5,372 | 25,584 | 1.00 | (0.96-1.04) | 0.98 | 1.04 | (1.00 - 1.09) | 0.04 |
| 4 | 5,175 | 23,791 | 1.04 | (0.10-1.08) | 0.07 | 1.04 | (1.00 - 1.08) | 0.06 |
| 5 - least deprived | 4,531 | 21,323 | 1.00 (ref) | | | 1.00 (ref) | | |

**Table A2.** Multivariable hazard ratios for death among those with laboratory confirmed COVID-19 and between 20 and 64 years of age. Data up to 13 May, England. Source: Public Health England Second Generation Surveillance System.

| | | | Univariable | | | Multivariable | | |
|---|---|---|---|---|---|---|---|---|
| | **number died** | **number total** | **HR** | **95% CI** | **p-value** | **aHR** | **95% CI** | **p-value** |
| **Sex** | | | | | | | | |
| Female | 1,202 | 37,677 | 1.00 (ref) | | | 1.00 (ref) | | |
| Male | 2,346 | 27,284 | 2.68 | (2.49 - 2.87) | <0.001 | 1.99 | (1.85 - 2.14) | <0.001 |
| **Age group** | | | | | | | | |
| 20-39 | 190 | 22,267 | 1.00 (ref) | | | 1.00 (ref) | | |
| 40-49 | 455 | 15,349 | 3.59 | (3.01 - 4.30) | <0.001 | 3.33 | (2.79 - 3.99) | <0.001 |
| 50-59 | 1,507 | 19,217 | 10.08 | (8.59 - 11.82) | <0.001 | 8.94 | (7.61 - 10.50) | <0.001 |
| 60-64 | 1,396 | 8,129 | 23.36 | (19.91 - 27.41) | <0.001 | 19.01 | (16.18 - 22.35) | <0.001 |
| **Ethnic group** | | | | | | | | |
| White - British | 2,255 | 44,588 | 1.00 (ref) | | | 1.00 (ref) | | |
| Asian / Asian British - Bangladeshi | 59 | 474 | 2.48 | (1.90 - 3.22) | <0.001 | 1.81 | (1.38 - 2.37) | <0.001 |
| Asian / Asian British - Chinese | 19 | 310 | 1.24 | (0.79 - 1.94) | 0.36 | 1.12 | (0.71 - 1.77) | 0.61 |
| Asian / Asian British - Indian | 164 | 2,734 | 1.21 | (1.03 - 1.42) | 0.02 | 1.06 | (0.90 - 1.25) | 0.50 |
| Asian / Asian British - Other | 122 | 2,468 | 1.00 | (0.83 - 1.20) | 0.99 | 0.92 | (0.77 - 1.12) | 0.42 |
| Asian / Asian British - Pakistani | 142 | 1,563 | 1.86 | (1.57 - 2.21) | <0.001 | 1.48 | (1.24 - 1.76) | <0.001 |
| Black / Black British - African | 197 | 2,461 | 1.57 | (1.36 - 1.82) | <0.001 | 1.04 | (0.89 - 1.22) | 0.59 |
| Black / Black British - Caribbean | 127 | 1,050 | 2.44 | (2.03 - 2.92) | <0.001 | 1.31 | (1.09 - 1.58) | 0.005 |
| Black / Black British - Other | 96 | 834 | 2.31 | (1.88 - 2.85) | <0.001 | 1.50 | (1.21 - 1.86) | <0.001 |
| Mixed - Other | 22 | 409 | 1.11 | (0.73 - 1.70) | 0.61 | 1.18 | (0.78 - 1.80) | 0.43 |
| Mixed - White and Asian | 8 | 224 | 0.74 | (0.37 - 1.49) | 0.40 | 0.87 | (0.43 - 1.74) | 0.70 |
| Mixed - White and Black African | 6 | 140 | 0.87 | (0.39 - 1.93) | 0.73 | 0.72 | (0.32 - 1.60) | 0.42 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Mixed - White and Black Caribbean | 12 | 161 | 1.56 | (0.89 - 2.76) | 0.12 | 1.50 | (0.85 - 2.66) | 0.16 |
| Other - Any other ethnic group | 156 | 2,614 | 1.19 | (1.01 - 1.41) | 0.04 | 0.92 | (0.77 - 1.09) | 0.34 |
| White - Irish | 19 | 324 | 1.23 | (0.78 - 1.93) | 0.37 | 0.96 | (0.60 - 1.53) | 0.87 |
| White - Other | 132 | 3,059 | 0.88 | (0.74 - 1.05) | 0.17 | 0.80 | (0.66 - 0.96) | 0.01 |
| **Region** | | | | | | | | |
| London | 1,092 | 13,436 | 1.00 (ref) | | | 1.00 (ref) | | |
| East Midlands | 227 | 3,063 | 0.95 | (0.82 - 1.10) | 0.50 | 1.00 | (0.86 - 1.16) | 0.98 |
| East of England | 355 | 5,828 | 0.76 | (0.67 - 0.86) | <0.001 | 0.96 | (0.84 - 1.09) | 0.52 |
| North East | 133 | 4,787 | 0.34 | (0.29 - 0.41) | <0.001 | 0.44 | (0.37 - 0.54) | <0.001 |
| North West | 499 | 11,311 | 0.55 | (0.50 - 0.62) | <0.001 | 0.64 | (0.57 - 0.72) | <0.001 |
| South East | 416 | 10,291 | 0.50 | (0.44 - 0.56) | <0.001 | 0.70 | (0.62 - 0.80) | <0.001 |
| South West | 139 | 3,350 | 0.51 | (0.43 - 0.62) | <0.001 | 0.63 | (0.52 - 0.76) | <0.001 |
| West Midlands | 412 | 6,276 | 0.85 | (0.76 - 0.96) | 0.007 | 0.87 | (0.77 - 0.98) | 0.03 |
| Yorkshire and Humber | 268 | 6,313 | 0.54 | (0.47 - 0.62) | <0.001 | 0.64 | (0.55 - 0.74) | <0.001 |
| **Deprivation quintile** | | | | | | | | |
| 1 - most deprived | 1,050 | 15,199 | 2.01 | (1.78 - 2.27) | <0.001 | 1.93 | (1.70 - 2.19) | <0.001 |
| 2 | 933 | 14,759 | 1.80 | (1.59 - 2.03) | <0.001 | 1.65 | (1.46 - 1.88) | <0.001 |
| 3 | 638 | 12,894 | 1.40 | (1.23 - 1.60) | <0.001 | 1.38 | (1.21 - 1.57) | <0.001 |
| 4 | 520 | 11,424 | 1.29 | (1.13 - 1.48) | <0.001 | 1.32 | (1.15 - 1.52) | <0.001 |
| 5 - least deprived | 381 | 10,302 | 1.00 (ref) | | | 1.00 (ref) | | |

**Table A3.** Multivariable hazard ratios for death among those with laboratory confirmed COVID-19 and over 64 years of age. Data up to 13 May, England. Source: Public Health England Second Generation Surveillance System.

| | | | Univariable | | | Multivariable | | |
|---|---|---|---|---|---|---|---|---|
| | number died | number total | HR | 95% CI | p-value | aHR | 95% CI | p-value |
| **Sex** | | | | | | | | |
| Female | 10,262 | 30,817 | 1.00 (ref) | | | 1.00 (ref) | | |
| Male | 14,417 | 32,277 | 1.40 | (1.36 - 1.43) | <0.001 | 1.47 | (1.44 - 1.51) | <0.001 |
| **Age group** | | | | | | | | |
| 65-69 | 1,830 | 6,873 | 1.00 (ref) | | | 1.00 (ref) | | |
| 70-79 | 6,937 | 19,060 | 1.50 | (1.43 - 1.58) | <0.001 | 1.55 | (1.47 - 1.64) | <0.001 |
| 80+ | 15,912 | 37,164 | 1.95 | (1.86 - 2.05) | <0.001 | 2.15 | (2.05 - 2.26) | <0.001 |
| **Ethnic group** | | | | | | | | |
| White – British | 20,617 | 53,291 | 1.00 (ref) | | | 1.00 (ref) | | |
| Asian / Asian British - Bangladeshi | 122 | 203 | 1.95 | (1.63 - 2.34) | <0.001 | 2.02 | (1.68 - 2.42) | <0.001 |
| Asian / Asian British - Chinese | 73 | 153 | 1.21 | (0.96 - 1.54) | 0.11 | 1.32 | (1.04 - 1.67) | 0.02 |
| Asian / Asian British - Indian | 580 | 1,300 | 1.19 | (1.10 - 1.29) | <0.001 | 1.28 | (1.18 - 1.39) | <0.001 |
| Asian / Asian British - Other | 288 | 671 | 1.08 | (0.96 - 1.22) | 0.18 | 1.22 | (1.08 - 1.38) | 0.001 |
| Asian / Asian British - Pakistani | 339 | 723 | 1.26 | (1.13 - 1.41) | <0.001 | 1.38 | (1.24 - 1.54) | <0.001 |
| Black / Black British - African | 230 | 608 | 0.90 | (0.79 - 1.03) | 0.13 | 0.98 | (0.86 - 1.13) | 0.83 |
| Black / Black British - Caribbean | 586 | 1,305 | 1.14 | (1.05 - 1.24) | 0.002 | 1.09 | (1.00 - 1.19) | 0.05 |
| Black / Black British - Other | 132 | 305 | 1.10 | (0.93 - 1.31) | 0.27 | 1.19 | (1.00 - 1.42) | 0.05 |
| Mixed – Other | 75 | 180 | 1.07 | (0.85 - 1.34) | 0.58 | 1.01 | (0.80 - 1.27) | 0.92 |
| Mixed - White and Asian | 22 | 48 | 1.23 | (0.81 - 1.87) | 0.33 | 1.37 | (0.90 - 2.09) | 0.14 |
| Mixed - White and Black African | 16 | 45 | 0.86 | (0.52 - 1.42) | 0.55 | 0.82 | (0.47 - 1.41) | 0.47 |
| Mixed - White and Black Caribbean | 34 | 76 | 1.11 | (0.80 - 1.56) | 0.53 | 1.11 | (0.79 - 1.55) | 0.56 |
| Other - Any other ethnic group | 418 | 1,028 | 1.02 | (0.92 - 1.12) | 0.74 | 1.05 | (0.95 - 1.16) | 0.36 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| White – Irish | 274 | 745 | 0.90 | (0.80 - 1.02) | 0.09 | 0.89 | (0.79 - 1.00) | 0.06 |
| White – Other | 819 | 2,050 | 1.01 | (0.94 - 1.08) | 0.76 | 1.02 | (0.95 - 1.10) | 0.60 |
| **Region** | | | | | | | | |
| London | 4,564 | 10,981 | 1.00 (ref) | | | 1.00 (ref) | | |
| East Midlands | 1,811 | 4,642 | 0.97 | (0.92 - 1.02) | 0.28 | 0.99 | (0.94 - 1.05) | 0.83 |
| East of England | 2,704 | 6,401 | 1.10 | (1.05 - 1.16) | <0.001 | 1.14 | (1.08 - 1.20) | <0.001 |
| North East | 1,429 | 4,113 | 0.89 | (0.84 - 0.94) | <0.001 | 0.91 | (0.85 - 0.97) | 0.004 |
| North West | 4,103 | 10,687 | 0.96 | (0.92 - 1.00) | 0.07 | 0.99 | (0.94 - 1.04) | 0.64 |
| South East | 3,249 | 8,398 | 0.94 | (0.90 - 0.98) | 0.008 | 0.97 | (0.93 - 1.02) | 0.28 |
| South West | 1,351 | 3,554 | 0.92 | (0.86 - 0.98) | 0.006 | 0.94 | (0.89 - 1.01) | 0.08 |
| West Midlands | 3,202 | 8,373 | 0.95 | (0.91 - 0.99) | 0.03 | 0.96 | (0.92 - 1.01) | 0.12 |
| Yorkshire and Humber | 2,223 | 5,843 | 0.96 | (0.92 - 1.01) | 0.16 | 0.99 | (0.94 - 1.04) | 0.66 |
| **Deprivation quintile** | | | | | | | | |
| 1 - most deprived | 5,695 | 14,383 | 1.05 | (1.00 - 1.09) | 0.03 | 1.09 | (1.04 - 1.13) | <0.001 |
| 2 | 5,312 | 13,528 | 1.03 | (0.98 - 1.07) | 0.24 | 1.04 | (1.00 - 1.09) | 0.05 |
| 3 | 4,727 | 12,294 | 1.00 | (0.96 - 1.05) | 0.87 | 1.02 | (0.97 - 1.06) | 0.48 |
| 4 | 4,652 | 11,993 | 1.01 | (0.97 - 1.05) | 0.62 | 1.02 | (0.97 - 1.06) | 0.47 |
| 5 - least deprived | 4,149 | 10,682 | 1.00 (ref) | | | 1.00 (ref) | | |

# Appendix B: Ethnicity classification in Hospital Episode Statistics (HES) data and in Office for National Statistics (ONS) data

| **HES ethnicity classification** | **ONS ethnicity classification** |
|---|---|
| White<br>A British<br>B Irish<br>C Any other White background | White<br>• English / Welsh / Scottish / Northern Irish / British<br>• Irish<br>• Gypsy or Irish Traveller<br>• Any other White background |
| Mixed<br>D White and Black Caribbean<br>E White and Black African<br>F White and Asian<br>G Any other mixed background | Mixed / Multiple ethnic groups<br>• White and Black Caribbean<br>• White and Black African<br>• White and Asian<br>• Any other Mixed / Multiple ethnic background |
| Asian or Asian British<br>H Indian<br>J Pakistani<br>K Bangladeshi<br>L Any other Asian background | Asian / Asian British<br>• Indian<br>• Pakistani<br>• Bangladeshi<br>• Chinese<br>• Any other Asian background |
| Black or Black British<br>M Caribbean<br>N African<br>P Any other Black background | Black / African / Caribbean / Black British<br>• African<br>• Caribbean<br>• Any other Black / African / Caribbean background |
| Other Ethnic Groups<br>R Chinese<br>S Any other ethnic group | Other ethnic group<br>• Arab<br>• Any other ethnic group |

This page is intentionally left blank

Report author: Steven Courtney
Tel: 0113 37 88666

**Report of Head of Democratic Services**

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

**Date: 23 June 2020**

**Subject: Work Schedule**

| | |
|---|---|
| Are specific electoral wards affected?<br>If yes, name(s) of ward(s): | ☐ Yes ☒ No |
| Has consultation been carried out? | ☒ Yes ☐ No |
| Are there implications for equality and diversity and cohesion and integration? | ☐ Yes ☒ No |
| Will the decision be open for call-in? | ☐ Yes ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, access to information procedure rule number:<br>Appendix number: | ☐ Yes ☒ No |

## 1. Purpose of this report

1.1 The purpose of this report is to consider the Scrutiny Board's work schedule for the initial meetings of the current municipal year.

## 2. Background information

2.1 All Scrutiny Boards are required to determine and manage their own work schedule for the municipal year. In doing so, the work schedule should not be considered a fixed and rigid schedule, it should be recognised as a document that can be adapted and changed to reflect any new and emerging issues throughout the year; and also reflect any timetable issues that might occur from time to time.

## 3. Main issues

3.1 On 16 March 2020, in light of the Covid-19 pandemic, Leeds City Council took the necessary step to cancel a number of planned meetings of various Committees, Boards and Panels. This included all Scrutiny Board meetings and any joint scrutiny arrangements where the Council acts as the lead authority.

3.2 Scrutiny Board Chairs were jointly involved in the decision-making process to cancel Scrutiny Board meetings in what were unprecedented and rapidly changing circumstances.

3.3 Scrutiny Board Chairs were actively engaged in the review and clearance of key decisions necessarily taken under the Council's Urgency provisions during this time, and call-in arrangements continued.

3.4 In cancelling Scrutiny Board meetings it was acknowledged that, after the urgency of the initial stages of the pandemic response, there would be opportunity to reflect and identify any lessons learned across different service areas and statutory local authority scrutiny functions would have an important role to play in this process.

3.5 With Council services focused on the urgent pandemic response and subsequent city recovery plan, the usual collaborative process of annual work programming for Scrutiny Boards was suspended.

3.6 However, in May 2020 all Scrutiny Boards were briefed on decision making relating to the areas of the pandemic response that fell within their respective remits.

3.7 In June 2020 public sessions of all Scrutiny Boards will re-start, albeit remotely. It has been agreed with Scrutiny Chairs that the first two sessions for each Board will be in a more streamlined format than traditional committee meetings. This is in recognition of the fact that new remote ways of conducting public meetings need to be tested and adapted, and many services are also continuing to respond to the consequences of Covid-19 and the subsequent easing of lockdown restrictions.

3.8 It should be noted that there remains a degree of uncertainty as to the final shape of the public committee calendar for the remaining months of the 2020/21 municipal year. This is due to the need to review the draft schedule in order to accommodate remote and/or blended committee meetings with very different resource requirements from the traditional buildings based sessions.

3.9 The initial iteration of the Board's work schedule for June and July is attached as Appendix 1 for consideration and agreement of the Scrutiny Board – subject to any identified and agreed amendments. It is anticipated that the Board will receive a work programme for the remainder of the year at its meeting on **14 July 2020**.

3.10 Executive Board minutes from the meeting held on 19 May 2020 are attached as Appendix 2. The Scrutiny Board is asked to consider and note the Executive Board minutes, insofar as they relate to the remit of the Scrutiny Board; and identify any matter where specific scrutiny activity may be warranted, and therefore subsequently incorporated into the work schedule.

<u>Developing the work schedule</u>

3.11 When considering any developments and/or modifications to the work schedule, effort should be undertaken to:

- Avoid unnecessary duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue.
- Ensure any Scrutiny undertaken has clarity and focus of purpose and will add value and can be delivered within an agreed time frame.
- Avoid pure "information items" except where that information is being received as part of a policy/scrutiny review.
- Seek advice about available resources and relevant timings, taking into consideration the workload across the Scrutiny Boards and the type of Scrutiny taking place.

- Build in sufficient flexibility to enable the consideration of urgent matters that may arise during the year.

3.12 In addition, in order to deliver the work schedule, the Board may need to take a flexible approach and undertake activities outside the formal schedule of meetings – such as working groups and site visits, where necessary and appropriate. This flexible approach may also require additional formal meetings of the Scrutiny Board.

## 4. Consultation and engagement

4.1.1 The Vision for Scrutiny states that Scrutiny Boards should seek the advice of the Scrutiny officer, the relevant Director(s) and Executive Member(s) about available resources prior to agreeing items of work.

### 4.2 Equality and diversity / cohesion and integration

4.2.1 The Scrutiny Board Procedure Rules state that, where appropriate, all terms of reference for work undertaken by Scrutiny Boards will include ' to review how and to what effect consideration has been given to the impact of a service or policy on all equality areas, as set out in the Council's Equality and Diversity Scheme'.

### 4.3 Council policies and the Best Council Plan

4.3.1 The terms of reference of the Scrutiny Boards promote a strategic and outward looking Scrutiny function that focuses on the best council objectives.

Climate Emergency

4.3.2 When considering areas of work, the Board is reminded that influencing climate change and sustainability should be a key area of focus.

### 4.4 Resources, procurement and value for money

4.4.1 Experience has shown that the Scrutiny process is more effective and adds greater value if the Board seeks to minimise the number of substantial inquiries running at one time and focus its resources on one key issue at a time.

4.4.2 The Vision for Scrutiny, agreed by full Council also recognises that like all other Council functions, resources to support the Scrutiny function are under considerable pressure and that requests from Scrutiny Boards cannot always be met.

Consequently, when establishing their work programmes Scrutiny Boards should:

- Seek the advice of the Scrutiny officer, the relevant Director and Executive Member about available resources;

- Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue;

- Ensure any Scrutiny undertaken has clarity and focus of purpose and will add value and can be delivered within an agreed time frame.

### 4.5 Legal implications, access to information, and call-in

4.5.1 This report has no specific legal implications.

### 4.6 Risk management

4.6.1 This report has no specific risk management implications.

## 5. Conclusions

5.1 All Scrutiny Boards are required to determine and manage their own work schedule for the municipal year. The latest iteration of the Board's work schedule is attached as Appendix 1 for consideration and agreement of the Scrutiny Board – subject to any identified and agreed amendments.

## 6. Recommendations

6.1 Members are asked to consider the matters outlined in this report and agree (or amend) the initial work schedule (as presented at Appendix 1) as the basis for the Board's work for June and July.

6.2 Members are asked to note that a further iteration of the work programme for the remainder of 2020/21 will be presented at the Board's meeting on 14 July 2020.

## 7. Background documents[1]

7.1 None.

[1] The background documents listed in this section are available to download from the council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

# Scrutiny Board (Adults, Health and Active Lifestyles)
# Work Schedule for 2020/2021 Municipal Year

**APPENDIX 1**

| June | July | August |
|---|---|---|
| **Meeting Agenda for 17th June 2020** | **Meeting Agenda for 8th July 2020** | **No Scrutiny Board meeting scheduled.** |
| *REMOTE SESSION*<br>• Update on Coronavirus (COVID19) pandemic – Response and Recovery Plan, including a briefing on the latest position with regard to those service areas that fall within the remit of the Scrutiny Board.<br>• Coronavirus (COVID19) pandemic – health inequalities. | *REMOTE SESSION*<br>• Update on Coronavirus (COVID19) pandemic – Response and Recovery Plan (including any areas of particular focus to be determined by the Board)<br>• Coronavirus (COVID19) pandemic – lessons learned<br>• Coronavirus (COVID19) pandemic – access to dental services in Leeds. | |
| **Working Group Meetings** | | |
| | | |
| **Site Visits** | | |
| | | |

**Scrutiny Work Items Key:**

| | | | | | |
|---|---|---|---|---|---|
| PSR | Policy/Service Review | RT | Recommendation Tracking | DB | Development Briefings |
| PDS | Pre-decision Scrutiny | PM | Performance Monitoring | C | Consultation Response |

**It is anticipated that the Board will receive a work programme for the remainder of the year at its meeting in July 2020.**

This page is intentionally left blank

**REMOTE MEETING OF EXECUTIVE BOARD**

**TUESDAY, 19TH MAY, 2020**

**PRESENT: (REMOTELY)** Councillor J Blake in the Chair

Councillors A Carter, R Charlwood, D Coupar, S Golton, J Lewis, L Mulherin, J Pryor, M Rafique and F Venner

**164 Chair's Opening Remarks**

The Chair welcomed everyone to the remote meeting of the Executive Board, which was being held as a result of the ongoing social distancing measures established in response to the Coronavirus pandemic.

On behalf of the Board, the Chair extended her thanks and appreciation to Council employees, together with all partner organisations and sectors across the city and the wider region for the extraordinary co-ordinated efforts which continued to be taken to safeguard and serve communities during these unprecedented times.

**165 Exempt Information - Possible Exclusion of the Press and Public**

**RESOLVED –** That, in accordance with Regulation 4 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt from publication on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) That Appendix 1 / A to the report entitled, 'East Leeds Secondary Place Provision – Proposed completion of Purchase of land at Torre/Trent Road from Arcadia', referred to in Minute No. 172 be designated as being exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within it relates to the financial or business affairs of the Council and/or another organisation. It is considered that the release of such information would, or would be likely to prejudice the Council's commercial interests in relation to other similar transactions. It is considered that the public interest in maintaining the exemption from publication outweighs the public interest in disclosing this information at this point in time.

**166 Late Items**

Agenda Item 7 (Update on Coronavirus (COVID-19) Pandemic – Response and Recovery Plan)

With the agreement of the Chair, a late item of business was admitted to the agenda entitled, 'Update on Coronavirus (COVID-19) Pandemic – Response and Recovery Plan'.

Given the scale and significance of this issue, it was deemed appropriate that a further update report be submitted to this remote meeting of the Board. However, due to the fast paced nature of developments on this issue, and in order to ensure that Board Members received the most up to date information as possible the report was not included within the agenda as originally published on 11th May 2020. (Minute No. 170 refers).

Agenda Item 8 (Impact of Coronavirus (COVID-19) upon Leeds City Council's 2020/21 Financial Position)

With the agreement of the Chair, a late item of business was admitted to the agenda entitled, 'Impact of Coronavirus (COVID-19) upon Leeds City Council's 2020/21 Financial Position'.

Given the scale and significance of this issue, it was deemed appropriate that an update report be submitted to this remote meeting of the Board. However, due to the fast paced nature of developments regarding this issue, and in order to ensure that Board Members received the most up to date information as possible the report was not included within the agenda as originally published on 11th May 2020. (Minute No. 171 refers).

**167 Declaration of Disclosable Pecuniary Interests**

There were no Disclosable Pecuniary Interests declared at the meeting.

**168 Minutes**

**RESOLVED –** That the minutes of the previous meeting held on 22nd April 2020 be approved as a correct record.

**INCLUSIVE GROWTH AND CULTURE**

**169 Devolution Deal for West Yorkshire - Review, Scheme and Consultation**

The Chief Executive submitted a report which provided an update on the latest stage of the process to implement the West Yorkshire Devolution Deal, as agreed between the region and Government in March 2020. The report included information on the outcome of the statutory governance review which had been undertaken and also sought approval to progress to the next phase involving public consultation on the draft Scheme, as appended to the submitted report.

In introducing the submitted report, the Leader highlighted that work on the devolution deal continued at pace, with it being reiterated that the intention was to progress in line with the timeframe as set out within the report. It was also highlighted that bearing in mind the current situation regarding the Coronavirus pandemic, discussions continued around allowing an element of

flexibility in the timeframe to ensure that all due diligence, consultation and scrutiny processes in respect of the proposals were fully undertaken as required.

In considering the submitted report, Members discussed and received further information on the following:-

- Given the current situation regarding the Coronavirus pandemic, emphasis was placed upon the importance of ensuring that members of the public and Elected Members of the Council were provided with appropriate opportunity to engage with and discuss the proposals as part of the consultation and communications exercises, which included the respective scrutiny functions at both the City Council and the Combined Authority. The importance of the democratic accountability and transparency of the process was reiterated, with the need for all Opposition Groups to receive briefings and communications on such matters, as appropriate, being highlighted;
- Proposals regarding the range of functions to be undertaken by the Mayoral Authority as part of the devolution deal were discussed, with it being highlighted that as a result of this process, no current functions would be transferred away from the City Council, unless by agreement of the Council. In response to specific enquiries, officers undertook to provide a Member in question with further information on how the function of housing and land acquisition would be delivered under the proposed model, with it being undertaken that a Member's specific comments around the setting of precepts would be fed into the relevant consultation processes;
- The potential economic benefits for the area arising from the adoption of the devolution deal for West Yorkshire were highlighted, with Members emphasising the importance of this, given the current financial position of Local Authorities in light of the Coronavirus pandemic.

**RESOLVED –**

(a) That having considered the Governance Review, as appended to the submitted report at Appendix 1, the Review's conclusions be endorsed, including that an Order under S104 and S105 in relation to the changes to constitutional arrangements considered in the Review and the delegation of additional functions to the Combined Authority would be likely to improve the exercise of statutory functions in relation to the Combined Authority's area;

(b) That the Board's consideration and comments regarding the draft Scheme for the establishment of the Mayoral Combined Authority, as detailed at Appendix 2 to the submitted report, be noted;

(c) That agreement be given for a public consultation exercise to be undertaken on the proposals contained within the Scheme, with the Board's consideration and comment upon the draft consultation questions, as detailed in Appendix 3 to the submitted report being noted;

(d) That the progression of engagement with the Combined Authority and other constituent Councils, as described within the submitted report, be agreed, with the Board's agreement also being given that the Managing Director of the Combined Authority shall, in consultation with the Leader and Chief Executive of this Council, be authorised to take any steps to finalise the preparation and publication of the Scheme and progress the public consultation exercise, as set out within the submitted report;

(e) That the updated timetable, as set out in Appendix 4 to the submitted report be noted, together with the next steps including, subject to the approval by constituent Councils and the Combined Authority, the submission of a summary of the consultation responses to the Secretary of State in August / September 2020, and to subsequently consent to any draft Order in September 2020 so that a mayoral combined authority model and associated changes may be adopted and implemented by May 2021, as set out in the Deal;

(f) That the proposals, as outlined in section 3.49 of the submitted report around political engagement throughout the devolution process, be agreed;

(g) That approval be given for all decisions taken by the Executive Board from this report, and as resolved above, be exempted from the Call In process on the grounds of urgency, as set out in paragraph 4.5.3 of the submitted report.

(The Council's Executive and Decision Making Procedure Rules state that a decision may be declared as being exempt from the Call In process by the decision taker if it is considered that the matter is urgent and any delay would seriously prejudice the Council's, or the public's interests. In line with this, the resolutions contained within this minute were exempted from the Call In process, as per resolution (g) above, and for the reasons as detailed within sections 4.5.3 of the submitted report)

**170 Update on Coronavirus (COVID19) pandemic – Response and Recovery Plan**

Further to Minute No. 161, 22nd April 2020, the Chief Executive submitted a report providing an update on the coronavirus (COVID-19) related work across the city, being driven by the response and recovery plan, as previously reported to the Board. The report provided information on organisational issues arising from the pandemic as well as a citywide update, and noted that the response and recovery plan aimed to mitigate the effects of the outbreak on those in the city, especially the most vulnerable, and prepare for the early stages of recovery. The report also noted that the city's multi-agency command and control arrangements were set within the national approach and guidance from the Government, plus the context of resilience and health partnership arrangements at a West Yorkshire level, and the Combined Authority.

With the agreement of the Chair, the submitted report had been circulated to Board Members as a late item of business prior to the meeting for the reasons as set out in section 9.1 of the submitted report, and as detailed in Minute No. 166.

In introducing the submitted report and providing an update on the current position, the Leader, on behalf of the Board, extended her thanks to all of those involved in the development and implementation of the response and recovery plan to date, including the continued delivery of detailed communications with all relevant parties. The Chief Executive reiterated such comments, paying tribute to all those who continued to deliver services across the city in response to the pandemic.

Members discussed and received further information on a number of issues, including:-

- The national role being undertaken by the Chief Executive with regard to the programme of testing, tracing and containing the virus, with Members highlighting the need for appropriate procedures to be implemented in respect of this at a localised level;
- The significant impact of the pandemic across a number of sectors. In response to enquiries regarding the hospitality sector, the Board was provided with information on the support being provided to that sector, with it being highlighted that provision of such support would be a key area of activity for the Council moving forward;
- Responding to a Member's comments regarding the delivery of formal meetings whilst social distancing measures remained in place, it was noted that formal meetings held remotely continued to take place and be scheduled, and that preparations were being made to deliver meetings which could potentially be attended both remotely and physically, however such physical attendance at meetings would not be introduced until Members felt it appropriate to do so, and that further Member discussions on such matters were required;
- A Member highlighted the importance of the Council taking into consideration service users' feedback and the outcomes from engagement processes when reviewing the Council's response to the pandemic and the adapted delivery of services. Responding to such comments, the Board received updates on a number of service areas including those delivered in crematoria, the distribution of food in communities / the delivery of associated grants, and the delivery of actions addressing period poverty;
- With regard to support for the agricultural sector, specific reference was made to the Council supported 'Pick for Britain' programme. Responding to a Member's enquiry, officers undertook to provide the Member in question with further details on how the Council was engaging in this initiative;
- Also, the Board received updates from several Executive Members regarding related matters within their respective portfolios. These included:-
    - Council decision making processes during the current period;

- Communication processes established to ensure that local communities remained informed of the help and support available to them, with a number of specific examples being provided;
- The current position within Care Homes in Leeds and the actions being taken to address the challenges which continued to be faced in this area, with specific tribute being paid to the work of frontline care workers during this time;
- The monitoring of the health inequalities agenda;
- The ongoing work aimed at delivering greater active travel provision, and the level of public engagement to date with the 'Common Place' platform.

In conclusion, the Chair highlighted the need for the Government to focus its efforts upon a more localised approach moving forward, with the key role of Local Authorities in such an approach being emphasised.

Finally, on behalf of the Board, the Leader asked all Directors to relay thanks to their respective teams for their continued efforts throughout such challenging circumstances.

**RESOLVED –**

(a) That the updated national context and local response to the Coronavirus (COVID-19) pandemic, as detailed within the submitted report, be noted;

(b) That the updated Response and Recovery plan, which includes the updated aims and objectives, be agreed;

(c) That the approach towards and messaging for running a safe city, as detailed within the submitted report, be agreed;

(d) That the submitted report and the comments made in respect of it during the discussion be noted in context with the more detailed report on the financial implications of the Coronavirus pandemic for the Council, as presented within Minute No. 171;

(e) That all Directors relay to their respective teams Members' thanks for their continued efforts throughout such challenging circumstances

.

**RESOURCES**

**171 Coronavirus (COVID-19) - Impact upon the Council's 2020/21 Revenue Budget**

The Chief Officer, Financial Services submitted a report providing an interim briefing on the forecast position for the Council when considering the scale of the financial challenge faced by the Authority in terms of 2020/21 and future years due to the COVID-19 pandemic.

With the agreement of the Chair, the submitted report had been circulated to Board Members as a late item of business prior to the meeting for the reasons

as set out in section 4.5.2 of the submitted report, and as detailed in Minute No. 166.

In introducing the submitted report, the Executive Member for Resources highlighted the scale of the financial challenge being faced by the Council, which it was emphasised remained an evolving picture. With regard to the recommendation that the Board write to the Government to ask for financial assistance to enable the Council to fulfil its requirements, it was highlighted that it was proposed that in addition to this, Government would be asked to provide support through the proposals, as set out within section 3.5.2 of the report.

Responding to a Member's enquiry regarding the options available to the Council moving forward, the Board was advised that a further report was scheduled to be submitted to the Board in June presenting the financial position over the next 2 years, which would also provide detail of the options available to the Council if further funding was not forthcoming from Government. Also, responding to a Member's enquiry, the Board noted that the issuing of a 'Section 114' report would only be undertaken as a final resort.

In response to a Member's enquiry, it was undertaken that Executive Members would continue to briefed on relevant matters between this Board meeting and the next scheduled meeting on 24th June.

Members highlighted the need for local Government to continue dialogue with the Treasury in order to explore all potential options available to financially assist Local Authorities during this time and moving forward.

A Member requested an update on the Council's commercial investment portfolio during this challenging period, arising from the national press coverage given to the issues that some Local Authorities were experiencing in this area. In response it was noted that currently there were no specific issues to report on such matters.

**RESOLVED –**

(a) That the position, as outlined in the submitted report by the Chief Officer, Financial Services concerning Leeds City Council's financial position as a consequence of the COVID-19 pandemic, be noted;

(b) That agreement be given for Executive Board to write to Government to ask for financial assistance to enable the Council to fulfil its requirements to deliver services to the residents of Leeds, and that in addition to this, Government support be sought on the proposals, as set out within section 3.5.2 of the report;

(c) That it be noted that a further report is to be submitted to Executive Board in June 2020 detailing the impact over the financial years 2020/21 and 2021/22 of the COVID-19 pandemic, together with an updated forecast budget position for 2021/22.

## LEARNING, SKILLS AND EMPLOYMENT

**172 East Leeds Secondary Place Provision - Proposed Purchase of Land at Torre/Trent Road from Arcadia**

Further to Minute No. 177, 20th March 2019, the Director of City Development and the Director of Children and Families submitted a joint report which looked to bring together three interconnected workstreams that had been progressed following the Board's previous approval in March 2019 to enter into negotiations with the Arcadia Group Ltd. for the potential acquisition of part of their site at Torre Road for the creation of the new East Leeds Secondary School. The report set out the current position regarding each of those workstreams and presented the rationale for the requirement of the Council to enter into the final Heads of Terms with Arcadia Group Ltd. for the purchase of the site to ensure the delivery of a new Secondary School for opening in September 2021.

Members provided support for the proposals as detailed within the submitted report and appendices.

Following the consideration of Appendix 1 / A to the submitted report, designated as being exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

**RESOLVED –**

(a) That the progress made to date regarding: the negotiations with Arcadia Group Ltd. for the purchase of part of their site for a new secondary school in East Leeds; the free school presumption under the terms set out in the Education and Inspections Act 2006 (section 6A) and the design development of the scheme to date, be noted;

(b) That approval be given for the Council to enter into the final Heads of Terms for the acquisition of 2.77ha of the unused playing field land at Torre Road owned by Arcadia Group Ltd from REDCASTLE (FREEHOLDS) LIMITED who are part of the Arcadia Group Ltd., for the new East Leeds secondary school; and that approval also be given to authorise the Director of City Development to use his delegated powers to approve the exchange and completion of the contract for the land purchase by the 31st July 2020;

(c) That 'authority to spend' the amount as detailed within the exempt appendix 1 / A to the submitted report on the purchase of the playing field land at Torre Road owned by Arcadia Group Ltd., be approved.

**DATE OF PUBLICATION:** THURSDAY, 21ST MAY 2020

**LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS:** 5.00 P.M. ON FRIDAY, 29TH MAY 2020