

FAIRER, HEALTHIER PRIMARY CARE IN LEEDS



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INTRODUCTION

In 2023, Leeds City Council partnered with the Institute of Health Equity to accelerate efforts to address health inequalities across the city. The *Fairer, Healthier Leeds* report, published at the end of the first year of work, highlights the **stark inequalities in health outcomes within the city** and proposes actions to address them. (1)

Primary care is uniquely positioned at the frontline of healthcare, offering a **vital opportunity to address health inequalities in local communities**. As the first point of contact for most patients, primary care services can have a **crucial role in identifying social determinants of health**, mitigating barriers to care, and connecting individuals with wider support networks. Tackling health **inequalities requires a comprehensive, population-level, whole system approach**, that addresses the social determinants of health, and **primary care can be utilised to achieve** this. Individual GP practices and Primary Care Networks (PCNs) have the ability to use data tools and coding with purpose-built templates to help tackle the city's unique demographics, socio-economic factors, and inequalities in health.

In Leeds, while most GPs wanted to support the emerging Marmot work, they were uncertain about where to begin and how they could contribute to the process. A dedicated collaborative team has been working closely together to develop a tailored approach that helps primary care focus on the social determinants of health that impact health outcomes, service usage and patient experience. By collaborating across systems, the cross-system partnership team was able to listen, understand and work together to develop a range of innovative tools that primary care can use to improve health outcomes for their practice populations. In Leeds, the partnership between public health and primary care and the **West Yorkshire Integrated Care Board (ICB)** represents a model of how collaborative leadership can drive meaningful change. (2) This report discusses the practical **tools and strategies Leeds created to embed health equity into everyday General Practice**.



TACKLING HEALTH INEQUALITIES IN PRIMARY CARE

Medical care accounts for a small portion of overall health outcomes. Much of the responsibility—and opportunity—for addressing the social determinants of health lies outside traditional healthcare settings. However, there is **growing recognition that healthcare systems** can play a crucial role in taking a **more proactive approach** to improve health and reduce inequalities.

Despite numerous calls from the NHS and professional organisations urging doctors to address their patients' social determinants of health, **there is limited evidence on what they can effectively** do. As one researcher stated: *“This can lead to a double bind: on the one hand, (doctors) know that the most important factors affecting patients’ health are the social determinants of health and yet they have minimal ability to influence the dominant underlying problems.”* (3)

Addressing **health inequalities in primary care** is essential because it is **often the first and most frequent point of contact for patients** within the healthcare system. Primary care providers are **uniquely positioned to identify social risk factors early, intervene with tailored support, and connect patients to local resources**. By systematically incorporating health inequality considerations into routine care—through tools like clinical templates—**primary care can move beyond treating illness to actively promoting health equity**. Strengthening primary care's role in tackling social determinants of health not only improves individual patient outcomes but also reduces pressure on secondary care services and contributes to a healthier, more resilient population.

Primary care networks (PCNs) and health inequalities

Primary Care Networks (PCNs) are essential in reducing health inequalities by improving access to care, integrating services, and tailoring interventions to local needs. Introduced in England in 2019, PCNs unite **GP practices, community services, pharmacies, and social care providers** to deliver more proactive, personalised, and coordinated care. Serving populations of **30,000 to 50,000**, they **focus on prevention, early intervention, and community-based healthcare**.

In Leeds, PCNs are vital in tackling health inequalities by designing **targeted healthcare interventions** based on local needs. By fostering **collaboration between practices and community services**, they provide a holistic approach, especially in **areas of higher deprivation** where conditions like cardiovascular disease and mental health issues are more prevalent.

However, challenges remain. **Inequalities in funding, workforce shortages, and varying patient demographics** across PCNs can **reinforce existing inequalities**. Ensuring PCNs succeed in a diverse city like Leeds requires addressing the unique socio-economic and cultural needs of each population through **equitable resource distribution and tailored healthcare strategies**.



LEEDS APPROACHES

The rationale for providing a variety of tools to address health inequalities in primary care was informed by the learning principles of Dr. Hasantha Jayasinghe, a GP partner at Chapeltown Family Surgery in Leeds, an area that faces elevated levels of health inequalities and social issues. Dr Jayasinghe does not have a clinical lead role but has worked the bulk of his career in areas of high deprivation and brings this experience to the team. Dr Jayasinghe is part of a children's multi-disciplinary team that reviews children with other professionals to determine best practice, and it was noted that the patients they were reviewing were impacted by health inequalities that would adversely affect their health outcomes.

The priority goal of this collaborative process was to ensure that the tools developed would be practical, widely used, and adaptable over time. The framework was developed for use across the UK, and the template was structured to be applicable beyond Leeds and easily adaptable to local contexts.

Dr. Jayasinghe posed four key questions for the working group to consider when tackling health inequalities, asking himself, "As a busy GP, how can I":

1. Understand Marmot's principles and apply them in my practice to improve both patient outcomes and my own work experience, while offering practical, real-time solutions?
2. Establish a clear pathway with straightforward solutions that do not require considerable time and effort on my part?
3. Build a system that can evolve and grow with me as I gain more confidence in addressing health inequalities in my daily work?
4. Collaborate effectively with other organisations, making the process as easy as possible for me?

These questions provided a **foundation for developing the following five tools and strategies** to reduce health inequalities in primary care.

A. HEALTH INEQUALITIES TEMPLATE

The *Health Inequalities Template* for primary care in Leeds was developed through a partnership between public health, primary care and the ICB — Leisa Batkin in the Localities and Primary Care Team in the Leeds Public Health team, Dr Hasantha Jayasinghe and Catherine Macdonald, a Senior Data Quality Officer at the Leeds Office of Data Analytics, part of the Leeds Integrated Digital Service embedded in the Leeds ICB office.

The template originated from a COVID welfare check template, which was rapidly created and deployed during the COVID pandemic to support clinically extremely vulnerable (CEV) populations. Following Leeds' designation as a Marmot Place, a decision was made to build upon existing successful initiatives. The original CEV Template, developed by Leisa and Catherine, had been monitored for usage, making it a logical foundation for integrating the Marmot principles. Using an established, widely adopted template provided a practical approach for primary care to address health inequalities in Leeds.

The *Health Inequalities Template* has since evolved into a structured tool designed to assess, monitor, and address health inequalities within the primary care system. It is embedded within Leeds' Primary care clinical systems and allows healthcare providers to:

- Record Read-coded information related to social determinants of health
- Access local solutions and referral options for patients
- Improve connections between primary care and local support services

The goal is to systematically document social issues affecting health—such as damp/mould in homes or fuel poverty—while strengthening primary care's ability to link patients with relevant local services. Clinical templates are a standard operating model in primary care, and this Health Inequalities Template is designed for efficiency, featuring embedded referral options and consistent messaging throughout.

KEY BENEFITS:

- **Data collection and analysis:** Captures data on health inequalities, service use, and patient demographics to identify trends and high-risk populations.
- **Risk stratification:** Categorises patients by health risks, enabling more tailored care delivery.
- **Community engagement and local referrals:** Encourages patient and community involvement in care decisions and facilitates referrals to address social factors affecting health. The “What Matters to Me” approach ensures patients can prioritise and address their most pressing issues.
- **Intervention planning and evaluation:** Supports the development of targeted, measurable interventions to reduce inequalities. Integrated data analytics and Read codes allow for detailed tracking and reporting through Leeds’ clinical systems. This unique data-sharing agreement enables hyper-local interventions, enhances collaboration with housing and social prescribing teams, and embeds social issue reviews into annual long-term condition assessments.

The *Health Inequalities Template* enables Leeds primary care to tackle health inequalities in a data-driven, evidence-based manner, aligned with the Marmot principles. It also serves a secondary function by generating detailed practice-level data for PCN profiles. The aim is for the **entire primary care workforce**—not just GPs—to **use this template**, reinforcing that addressing health inequalities is a collective responsibility.

EVALUATING IMPACT

A tracking marker has been added to monitor usage of the *Health Inequalities Template*, helping to engage more PCNs and facilitate the sharing of best practices among frequent users.

The aim is to extract data from the clinical system every three months to assess whether the Health Inequalities Template is being used, by whom, for what purpose, and in which locations across Leeds.

Early data analysis shows that the Health Inequalities Template is being used throughout Leeds, including areas beyond those with higher levels of deprivation. It is predominantly used by GPs, which is an unexpected but encouraging outcome.

It is hoped the *Health Inequalities Template* will be included in the new social prescribing contract launching in 2025, with a focus on increasing adoption among Additional Roles Reimbursement Scheme (ARRS) staff, such as in-house link workers. ARRS roles are key to transforming primary care to tackle health inequalities by diversifying teams and shifting and improving the way healthcare is delivered.



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Health Inequalities

The conditions in which people are born, grow, live, work and age shape their health. This template will give you the space to collect important data on these social determinants of health and offer solutions for issues you may uncover.

Throughout this template we will align your work to the key Marmot principles. Each tab repeats the contextual questions about the conditions people find themselves in but also questions relevant to the stage in life they are at. Its aim is to help busy healthcare professionals easily access resources and to help co-ordinate interdisciplinary working.

The Marmot Review set 8 principles to reduce health inequalities

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

Population groups commonly affected by health inequalities:

Protected Characteristics
 Age, Disability, Gender Reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation

Socio-economically deprived population
 includes impact of wider determinants eg education, low-income, occupation, unemployment and housing, digitally left behind

Inclusion health and vulnerable groups
 for example gypsy, roma, travellers and boater communities, homelessness, offenders/ex-offenders and sex workers

Geography
 for example population composition, built and natural environment, levels of social connectedness and features of geographies like urban, rural and social

Web Links

- [Tackling Health Inequalities Toolkit](#)
- [Leeds Health Observatory](#)
- [New Marmot Places Work Announc](#)
- [Health Inequalities in a nutshell - th](#)
- [Health Inequalities \(with subtitles\) \](#)
- [Core20PLUS5 to reduce healthcare](#)
- [TGT Lds - helping with the cost of lv](#)

Quick Actions

- [Patient Consultation](#)
- [Automatic Consultation](#)
- [Quick Print Prescriptions \(using ...](#)
- [New Coded Entry](#)
- [Appointment Ledger](#)
- [Free Slot Search](#)
- [New Recall](#)
- [Visits](#)
- [Path Results-View](#)
- [Path/Radiology Request](#)
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- [New Task...](#)
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- [Send Email](#)
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Housing

Healthy standard living for all

Ethnic recording codes

Read in Language

- ☐ Reads Amharic (SNOMED: ...
- ☐ Reads Arabic (SNOMED: 1...
- ☐ Reads Burmese (SNOMED:...
- ☐ Reads Chinese (SNOMED: ...
- ☐ Reads Chinese - Simplified ...
- ☐ Reads English (SNOMED: 1...

Do you worry about paying your rent

Do you struggle to pay utility bills?

Can you keep your house warm?

Do you have enough food to eat?

Referral to affordable warmth programme

Does patient wear appropriate clothing?

Can the patient provide personal care products?

Are you ok with digital systems (NHS platforms, online appt booking)?

Digital ability

To check if IT literate ask them to sign up to [Digital Inclusion](#)

Is your home a good place to live?

Inadequate housing

Bed Bugs / Dust Mites / Fleas / Pet Dander

Damp in the House

Mould growth in home

Are there any issues at home?

Alcohol misuser in household

Drug misuser in household

Alleged DV in househouse - please specify

Do you feel safe in your community?

Do you have acces to outdoor area at home?

Relationship with neighbours-please free text

Victim of crime

Housing

Home Status

Harrassment by landlord

We are working closely with a trusted organisation called **Care and Repair** who can offer some support and advice with the cost of fuel and can provide equipment that could help save you some money and provide interventions that improve home efficiency. Call Care & Repair on - **0113 2406009** or email Carerepairleeds.homeplus@nhs.net for a phone call or home visit.

Care & Repair Referral (signposting to fami...

Damp or mould recorded in last 1 year

Housing - inadequate: bed bugs/flea/cockroach L1yr view ha

Please note, it is no longer necessary for a GP to write a letter on behalf of the patient to the Housing Team. A letter has been created for any staff member in practice to print and give to the patient so they can take it along to the Housing Team. The letter holds the patients LTC, medications and fit notes.

[Housing Letter for Patient](#)

Letter to housing

Please note the letter will needing checking with the patient to ensure they are happy with what information it has pulled through

Web Links

- [Care and Repair Leeds](#)
- [Streetlink - sleeping rough](#)

Quick Actions/Clinical Tools

- [New Coded Entry](#)
- [Appointment Ledger](#)
- [Free Slot Search](#)
- [New Recall](#)
- [Visits](#)
- [New Task...](#)
- [Messaging...](#)
- [Patient Consultation](#)
- [Automatic Consultation](#)
- [Path Results-View](#)
- [Path/Radiology Request](#)
- [Send SMS Message](#)
- [Send Email](#)
- [Launch Communications...](#)

Template Links

- [Breathe Easy Homes](#)
- [Reasonable Adjustments Tem...](#)

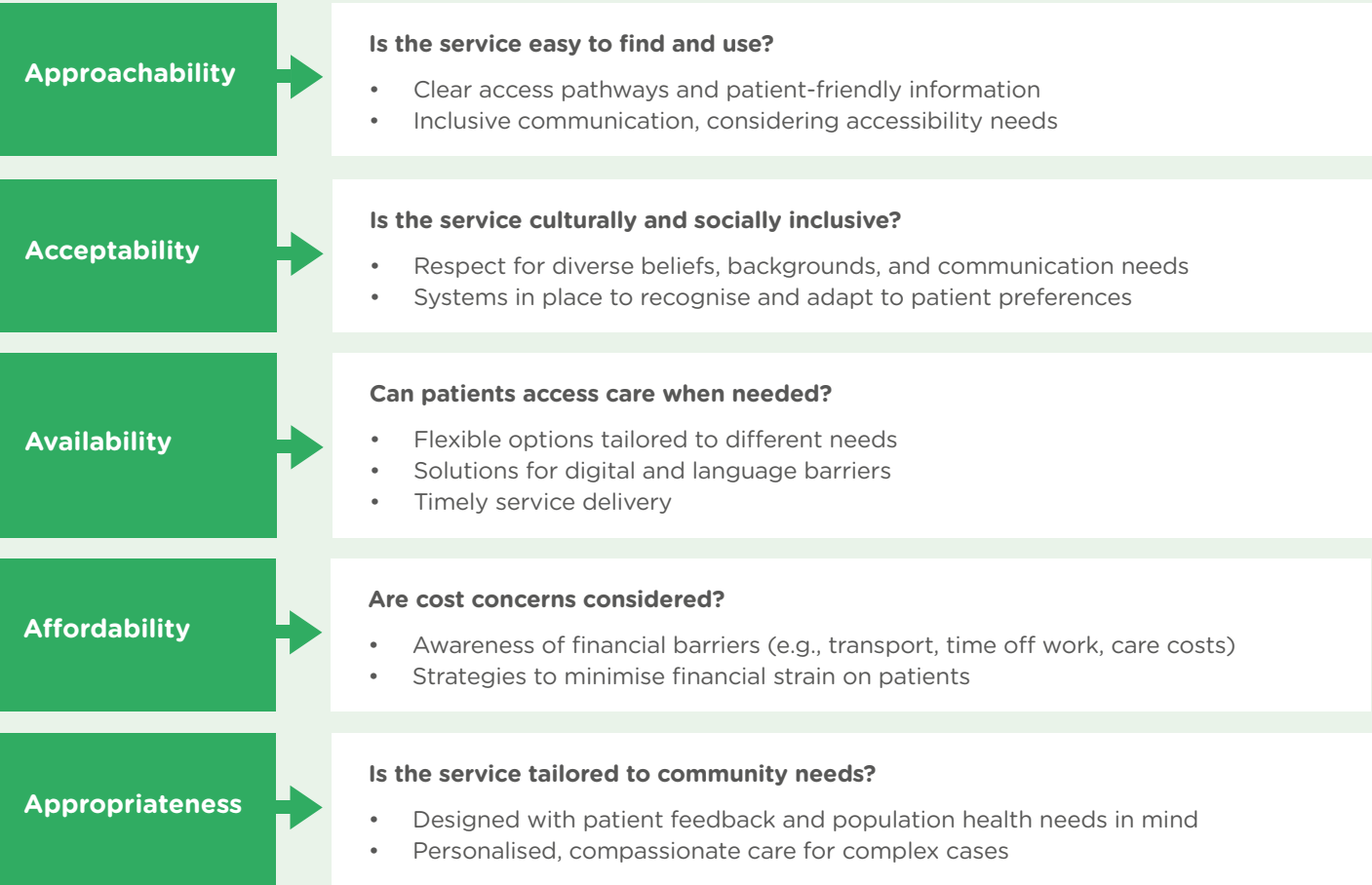
B. 5As OF ACCESS: A GUIDE TO IMPROVING HEALTHCARE ACCESS

Access to GPs in England has become increasingly challenging, with long wait times, workforce shortages, and difficulties securing appointments – all of which exacerbate healthcare inequalities. Research shows that communities in areas of high deprivation face greater barriers to accessing primary care, contributing to worse health outcomes. The inverse care law, first proposed by Tudor Hart in 1971, remains relevant today—those who need care the most often struggle the most to access it. (4)

In 2024 the Royal College of Physicians found that areas of higher deprivation in England have fewer GPs per capita, despite having higher levels of chronic illness and complex health needs. (4) Factors such as digital exclusion, language barriers, and financial constraints (e.g., transport costs or time off work) further disadvantage lower-income groups. (6)

Improving access to primary care is complex and multi-dimensional, extending far beyond simply offering more appointments. Recognising this, the Leeds Localities and Primary Care team, in the Public Health Department in Leeds City Council, led a collaborative effort across the primary care system to develop the 5 As of Access. This framework ensures that when addressing emerging challenges, the focus begins with understanding the real barriers experienced by patients rather than relying on system-based assumptions about why people delay or avoid seeking care.

5AS OF ACCESS FOR PRIMARY CARE



The *5 As of Access* approach is being implemented across various primary care projects in Leeds. In Seacroft, an area of high-deprivation, the Seacroft PCN is working with local community organisations to create a clear pathway for individuals to get tested and treated in their community.

The *5 As of Access* approach is also being reviewed for integration into the refresh of Leeds Teaching Hospitals Trust’s health inequalities strategy.

C. BESPOKE PCN INFOGRAPHICS

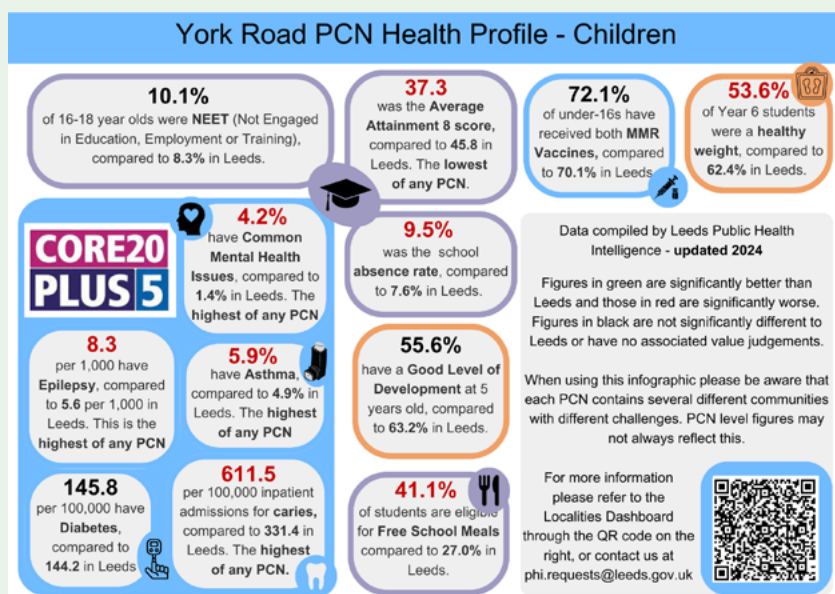
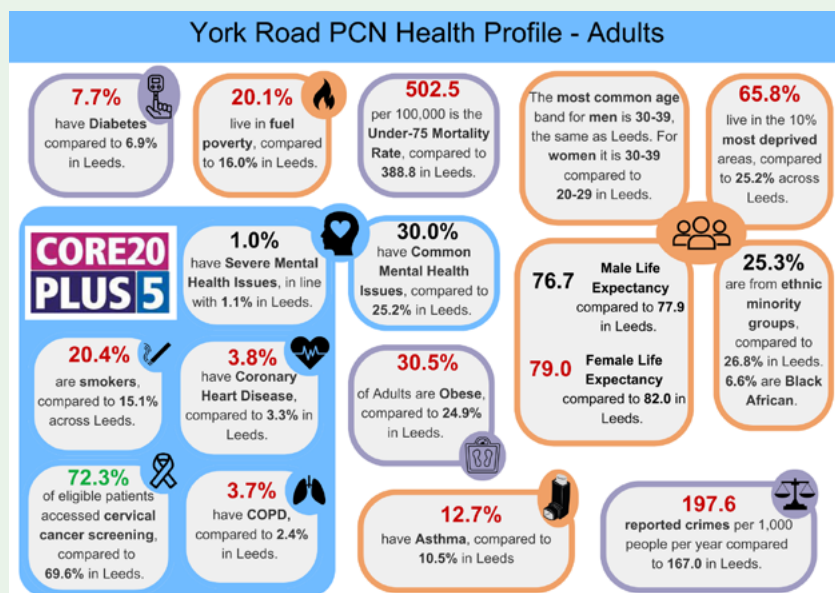
The Public Health team, in collaboration with the Public Health Intelligence team at Leeds City Council, created PCN infographics to help primary care teams better understand their practice populations. While **GPs** are familiar with their patients, they **often lack access to specific data sets and insights to tackle inequalities**, particularly those **related to the NHS England Core20PLUS5 approach**. (7) To address this, each infographic was designed with consistent branding, typography, and fonts, highlighting the Core20PLUS5 indicators for each PCN in Leeds. Unique data sets for each PCN are also included, allowing for a clear comparison of how each one differs from others. This approach makes it easy to visualise and understand the specific needs of each PCN.

Infographics are a useful tool that provides a **clear and concise visual representation** of key health and demographic data. These tools help translate complex data into actionable information, supporting **better decision-making and resource allocation**.

The **Leeds PCN infographics** offer **valuable insights** for **health professionals, policymakers, and community stakeholders**. By highlighting key trends, they help identify health inequalities and service needs, including:

- **Chronic Conditions:** Focus on **Core20PLUS5 indicators** such as diabetes, asthma, and heart disease.
- **Socio-Economic Factors:** Show levels of **deprivation, unemployment, and education attainment**, which impact health outcomes.
- **Healthcare Access:** Identify areas with **limited services**, helping guide resource allocation.
- **Population Demographics:** Break down data by **age, ethnicity, and gender** to support targeted interventions.

PCN infographics reveal stark contrasts between different areas—for example, wealthier areas may need services tailored to an ageing population, while deprived areas face higher rates of smoking, obesity, and mental health conditions. These insights support targeted, equitable healthcare planning. They also **enhance transparency and trust**, fostering greater community engagement in public health efforts.



D. PRIMARY CARE HEALTH INEQUALITIES ACTION LEARNING GROUP

The *Primary Care Health Inequalities Action Learning Group* in Leeds is a **collaborative initiative** aimed at reducing health inequalities within communities. *The Group* provides a safe, supportive space for members to ask questions about health inequalities - an invaluable opportunity for primary care that is not offered anywhere else in the city.

The Group brings together the primary care workforce and other system partners to address various healthcare challenges, always applying a health inequalities perspective to the chosen theme. *The Group* **meets monthly** to share best practices and provide mutual support. Uniquely, it offers an **open-door policy for all members of the primary care workforce**, regardless of role or responsibility, as *the Group* recognises that tackling health inequalities is everyone's responsibility.

The *Primary Care Health Inequalities Action Learning Group* has been meeting for over 12 months and has seen increasing attendance. Looking ahead, *the Group* plans to become an operational component of the broader Health Inequalities system leadership team, providing a platform to raise concerns and share recent findings. Based on feedback, they will increase the frequency of meetings in 2025, and an annual report on *the Group's* activities will also be published later this year.

Using an **action learning approach**, *the Group* identifies systemic barriers to health equity and works collectively to address them. Members share experiences, insights, and best practices to co-create solutions that improve healthcare access, services, and the broader social determinants of health.

Chaired by **Clinical Director Mo Sattar**, *the Group* fosters continuous learning and encourages sustainable, community-driven improvements in public health across Leeds.

E. GP TRAILBLAZERS

The **GP Trailblazer Programme** is a national initiative aimed at tackling health inequalities in primary care by supporting innovative, community-led approaches. (8) The Trailblazer scheme was modelled on the Deep End Pioneer Scheme, which started in Glasgow in 2016. The ambition was to support newly qualified GPs to work in areas of socioeconomic deprivation utilising a structured educational programme, coaching and peer support. Fellows are expected to use their time on the programme to work closely with their practice and/or community to complete at least one quality improvement project during their 12 months on the scheme.

The Yorkshire and Humber Trailblazer Programme provides funding to support practices in enabling one of their GPs to participate in professional development and structured education. GPs are able to focus on projects that improve health outcomes, such as enhancing population health for patients, developing their own skills, and building their own resilience. The Trailblazer scheme also aims to help local practices recruit and retain GPs in areas of high deprivation, ensuring better healthcare access for communities in need.

Since its establishment in 2018, the **Yorkshire and Humber GP Trailblazer Fellowship** has played a key role in tackling health inequalities. Of the **81 fellows in the region, 13 (16%) have been hosted by practices in Leeds**, where they have led impactful projects that have improved patient care and strengthened approaches to reduce health inequalities.

The Leeds GP Trailblazer Fellows have delivered a range of equity focussed quality improvement initiatives, including:

- **Improving access to dental care** by creating a referral pathway between the acute dental hospital and primary care dental practices.
- **Increasing uptake of the Healthy Start vitamin and voucher scheme** by raising awareness among eligible families.
- **Enhancing well-being for refugees and asylum seekers** by organising events during national holidays, running recurring sporting activities.
- **Improving childhood respiratory health** in the Burmantofts, Harehills & Richmond Hill PCN, an area with high levels of deprivation.
- **Developing equity focussed approaches to childhood obesity.**
- **Launching a menopause clinic for Asian women**, providing culturally tailored support and education on managing this life stage.

Many of these projects have continued to **grow and evolve beyond the fellows' time on the scheme**, leaving a lasting impact on primary care in Leeds and ensuring **ongoing progress in tackling health inequalities**.

LESSONS LEARNED AND FUTURE OPPORTUNITIES

Developing health inequality resources for primary care in Leeds has provided the following insights for healthcare professionals, policymakers, and community stakeholders.

- **Tackling health inequalities in primary care requires a multi-sectoral, integrated approach.** Co-production, involving primary care teams, public health, and the public health intelligence team ensured the resources produced were practical, relevant, and tailored to local needs. This approach ensures that interventions are both patient-centred and embedded within broader public health strategies.
- **Strengthening partnerships between primary care and public health was an unexpected yet vital outcome,** one that continues to grow. The success of the project can be attributed to the extensive experience of the team, which included members from both public health and primary care. Real partnership working—where diverse professionals take the time to understand each other’s roles—was essential. Collaborating to ‘make it make sense’ required dedication and tenacity.
- **Accessibility and usability were critical.** Given the time constraints faced by primary care professionals, resources needed to be concise, actionable, and easily integrated into daily workflows. The inclusion of digital formats and integration with electronic health records made it easier for GPs to engage with the materials.
- **Addressing health inequalities requires systemic change, not just individual behaviour change.** While patient education is valuable, tackling social determinants of health—such as housing, employment, language barriers, and access to support—is key.
- **These tools are making a difference.** Providing primary care professionals with practical, evidence-based tools while fostering collaboration with wider services can improve healthcare access and outcomes for disadvantaged populations. The PCN infographics provide accessible entry points for shaping priorities, the Health Inequalities Template offers quick solutions, and the Primary Care Health Inequalities Action Learning Group serves as a space for learning and curiosity. The 5 A’s Approach provides a starting point for new projects, and the Trailblazer group helps build skills and resilience.
- **Evaluation and sustainability are essential.** By establishing regular feedback loops, Leeds and its system partners could refine resources to ensure they remained relevant and effective. Embedding these tools into professional development, such as training modules or quality improvement initiatives, maximises their long-term impact.
- **Sustainable funding for the Trailblazer scheme is essential for its future growth.** Ensuring ongoing financial support will enable the continued development of GPs in Leeds and beyond, fostering their ability to tackle health inequalities effectively. Additionally, expanding eligibility for the Trailblazer scheme to include GPs further along in their careers could enhance learning and development opportunities around health inequalities across the workforce.

All of this was achieved without any funding, which remains a significant challenge. There is a limit to how much time can be taken from individuals who are already extremely busy. Team leaders have mastered the art of gentle nudging and protest, consistently raising the issue of health inequalities at every opportunity and challenging the status quo when necessary. Considering financial incentives for this work within the Leeds system would help support efforts, raise awareness of health inequalities, and ensure a collaborative approach to addressing the long-term effects of poverty and health inequalities.

CONCLUSION

The collaborative approach between primary care and public health in Leeds demonstrates the power of partnership in tackling health inequalities. The success of initiatives such as the Health Inequalities Template, PCN infographics, and the GP Trailblazer Programme highlights the importance of proactive leadership and cross-sector coordination in reducing inequalities.

However, addressing health inequalities is an ongoing process that requires sustained commitment. Challenges remain, including funding constraints, workforce pressures, and systemic barriers. By continuing to prioritise equity, strengthen partnerships, and champion practical solutions, primary care can ensure that healthcare services work for everyone—especially those most in need.

In an era of growing health inequalities, primary care must not only respond to treating the results of inequalities but actively seek to prevent and reduce them. Addressing health inequalities requires commitment, leadership, and cross-sector collaboration. Strengthening partnerships between primary care, public health, and local services ensures that interventions are both targeted and sustainable.

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