



HEALTH AND WELLBEING BOARD

**Meeting to be held in Room 1, The Carriageworks, The Electric Press,
3 Millennium Square, Leeds, LS2 3AD on**

Monday, 19th February, 2018 at 10.30 am
(with a pre-meeting for Board Members from 9.30 am)

MEMBERSHIP

Councillors

R Charlwood (Chair)
D Coupar
L Mulherin

S Golton

G Latty

Representatives of Clinical Commissioning Groups

Dr Jason Broch	NHS Leeds North CCG
Alistair Walling	NHS Leeds South and East CCG
Dr Gordon Sinclair	NHS Leeds West CCG

Nigel Gray	NHS Leeds North CCG
	NHS Leeds South and East CCG
Phil Corrigan	NHS Leeds West CCG

Directors of Leeds City Council

Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adults and Health
Steve Walker – Director of Children and Families

Representative of NHS (England)

Moirá Dumma - NHS England

Third Sector Representative

Representative of Local Health Watch Organisation

Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers

Sara Munro - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Safer Leeds Representative

Superintendent Sam Millar – West Yorkshire Police

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
2			WELCOME AND INTRODUCTIONS APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS To consider any appeals in accordance with Procedure Rule 15.2 of the Access to Information Rules (in the event of an Appeal the press and public will be excluded) (*In accordance with Procedure Rule 15.2, written notice of an appeal must be received by the Head of Governance Services at least 24 hours before the meeting)	
3			EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC 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. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- 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:-	

4

LATE ITEMS

To identify items which have been admitted to the agenda by the Chair for consideration

(The special circumstances shall be specified in the minutes)

5

DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

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.

6

APOLOGIES FOR ABSENCE

To receive any apologies for absence

7

OPEN FORUM

At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.

8

MINUTES

To approve the minutes of the previous Health and Wellbeing Board meeting held 23rd November 2017 as a correct record.

(Copy attached)

1 - 10

9		LEEDS HEALTH AND WELLBEING BOARD: REVIEWING THE YEAR 2017-2018 To consider the report of the Chief Officer, Health Partnerships, which provides a round-up of activity commissioned or directed by the Health and Wellbeing Board and guided by the Leeds Health and Wellbeing Strategy over the last 12 months. (Report attached)	11 - 58
10		JOINT STRATEGIC NEEDS ASSESSMENT: MORE COMPREHENSIVE APPROACH TO CITY- WIDE ANALYSIS To consider the joint report of the Chief Officer, Health Partnerships and the Head of LCC Intelligence and Policy which presents a forward-looking, partnership approach to the ownership, production and utilisation of the Joint Strategic Needs Assessment, considering the wider determinants of health and wellbeing and seeking to facilitate policy linkages across Best Council and Best City Priorities. (Report attached)	59 - 66
11		LEEDS ACADEMIC HEALTH PARTNERSHIP STRATEGY To consider the report of the Chief Officer, Health Partnerships, on the progress made by the Leeds Academic Health Partnership to establish a Strategic Framework of priorities; including a summary of its programme of active projects to deliver these. The report acknowledges the role of the Leeds Academic Health Partnership in a wider strategic context of the Council's Corporate Plan priorities to create a strong economy and compassionate city and to align with the Leeds Health and Well Being Strategy, Leeds Health and Care Plan and Leeds Inclusive Growth Strategy. (Report attached)	67 - 102

12		PHARMACY NEEDS ASSESSMENT 2018-21 To consider the report of the Director of Public Health which provides a summary of the findings of the new Pharmacy Needs Assessment 2018-2021 which has been produced after a thorough and robust process, including a number of consultation measures. The PNA is submitted for approval by the Health and Wellbeing Board prior to publication by 1st April 2018 deadline. (Report attached)	103 - 252
13		PROGRESSING THE NHS LEEDS CLINICAL COMMISSIONING GROUPS PARTNERSHIP ANNUAL REPORT 2017-2018 To consider the report of the Communications Manager, NHS Leeds Clinical Commissioning Groups Partnership, which demonstrates how the Clinical Commissioning Group Annual Report has documented its contribution to the joint health and wellbeing strategy. The report also provides an opportunity for members to agree on the key achievements of the Health and Wellbeing Board in delivering the Leeds Health and Wellbeing Strategy 2016-2021. (Report attached)	253 - 278
14		FOR INFORMATION: IBCF (SPRING BUDGET) Q3 2017/18 RETURN AND BCF PERFORMANCE MONITORING Q3 2017/18 RETURN To note for information, receipt of the joint report from the Chief Officer, LCC Adults & Health and the Director of Operations & Delivery, Leeds CCGs Partnership, on the contents of the national iBCF return and the Leeds HWB BCF Performance Monitoring return for 2017/18 Quarter 3 which were previously submitted nationally following circulation to members for comment. (Copy attached)	279 - 298

FOR INFORMATION: LEEDS HEALTH AND CARE QUARTERLY FINANCIAL REPORTING

To note, for information, receipt of the report of Leeds Health and Care Partnership Executive Group (PEG) providing an overview of the financial positions of the health & care organisations in Leeds, brought together to provide a single citywide quarterly financial report.

(Copy attached)

ANY OTHER BUSINESS

DATE AND TIME OF NEXT MEETING

To note the following arrangements:

- a) Board workshop – Thursday 19th April 2018 at 9:30 am
- b) Formal Board meeting - proposed as Thursday 14 June 2018, 12:30-15:30 pm.

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 named 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.

HEALTH AND WELLBEING BOARD

THURSDAY, 23RD NOVEMBER, 2017

PRESENT: Councillor R Charlwood in the Chair

Councillor L Mulherin

Representatives of Clinical Commissioning Groups

Alistair Walling	NHS Leeds South and East CCG
Dr Gordon Sinclair	NHS Leeds West CCG
Nigel Gray	NHS Leeds North CCG
Phil Corrigan	NHS Leeds West CCG

Directors of Leeds City Council

Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adults and Health
Sue Rumbold – Chief Officer, Children and Families

Representative of NHS (England)

Moira Dummer - NHS England

Third Sector Representative

Heather Nelson – Black Health Initiative
Hannah Howe – Forum Central

Representative of Local Health Watch Organisation

Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers

Sara Munro - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Safer Leeds Representative

Michelle de Souza – Communities & Environment

31 Welcome and introductions

Councillor Charlwood welcomed all present and brief introductions were made. The Chair reported that Lesley Sterling-Baxter had resigned from her role as Co-Chair of Leeds Healthwatch and from the Health and Wellbeing Board. Councillor Charlwood agreed to write to Lesley to express the Board's thanks for her work on the Board as the voice of the public and health system users.

32 Appeals against refusal of inspection of documents

There were no appeals against the refusal of inspection of documents.

33 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

34 Late Items

No formal late items of business were added to the agenda, however Members had received a supplementary pack to agenda Item 12 (iBCF (Spring Budget) and BCF 2017/18 Quarter 2 Returns) containing Appendix 2 of the report which was not available at the time the agenda for the meeting was despatched. The document had also been published to the LCC website (Minute 42 refers).

35 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interests.

36 Apologies for Absence

Apologies for absence were received from Councillor Coupar, Councillor Golton, Councillor G Latty, Jason Broch, Steve Walker and Sam Millar. Sue Rumbold and Michelle de Souza attended the meeting as substitutes.

37 Open Forum

Community engagement – In response to a representation from a member of the public about the take-up; promotion, and value of public engagement in shaping the Leeds Health & Care Plan, the Chair responded that the main focus of the consultation with Leeds Community Committees was to encourage discussion in local areas, with local representatives as this was important for shaping the future health and care system.

The Executive Lead, Leeds Health & Care Plan, acknowledged that each Community Committee operated differently in response to its locality. Further additional public consultation was planned for 2018, including public events; specific website and events targeted towards harder to reach groups and communities.

38 Minutes

RESOLVED – To agree the minutes of the meeting held 28th September 2017 as a correct record.

39 Inclusive Growth Strategy - Alignment with Health and Wellbeing Strategy

The Board considered a report on the recent work to review and replace the Leeds Inclusive Growth Strategy for 2017-2023. A copy of the draft Leeds Inclusive Growth Strategy (IGS) was attached to the report as an appendix.

The Chief Officer, Health Partnerships, reported on a recent meeting with West Yorkshire Combined Authority. He emphasised the need for the IGS to include health and care skills based on the emerging evidence of the close links between skills and education supporting good health; and in the knowledge that the health, care and medical sectors will be one of the fastest growing.

Simon Brereton, LCC Economic Development Programme Leader, presented the Strategy which anticipated Leeds continued economic growth and

included proposals to meet that challenge. He posed the question 'how do we ensure it reaches all parts of the city?' and highlighted the following issues:

- Leeds's jobs growth does not reach right across the jobs spectrum. There is growth in degree level qualification jobs but middle sector job numbers are declining; and there is a gap in the market which is traditionally filled with low level skill, administrative, process jobs.
- Two thirds of the working population have not attained a level 4 qualification or above.
- Leeds has a young population that is getting younger; and we need to ensure that they have the qualifications and skills to sustain employment. The ageing population means that we need to cater for those who have been in the job market for a long time.
- The IGS includes '12 Big Ideas' to tackle the issues and targets 7 job priority sectors, including the health and medical sector and the aging population.
- The IGS proposed measures to tackle poverty across the city – 150,000 residents live within the 10% most deprived localities in England. Although growth was predicted, a key issue would be how to ensure that growth did not contribute to a widening disparity between rich and poor in the city.
- The IGS anticipated 80,000 new jobs by 2020, with a further 600,000 posts released through the churn of retirement or movement.
- The concentration of low paid jobs in Universities, the health and care and education sectors was noted - despite the work done to achieve the living or minimum wage; and the reliance on these sectors to equip the city for economic growth.
- Future changes to the city infrastructure through the HS2 rail link and anticipated doubling in size of the city centre will impact on the economy; jobs and how we travel to and from the workplace. Poverty and low pay required consideration at the Leeds City Region level. It was noted that people on low pay only travel an average of 1 mile for work – therefore jobs must be created throughout the city, closer to where people on low pay live.

In conclusion, a focus for the meeting was to consider the Board's influence to challenge to bring about changes to wages and investment in order to promote economic growth and reduce poverty.

The Board's discussions focussed on the following matters:

Local Procurement and the power to affect change locally in Leeds. Local commissioners could influence and contribute as employers and buyers - making sure low paid staff are supported and paid a living wage; seeking high quality and supporting not for profit care for local communities through partnerships with social enterprise. Future commissioning to consider care delivery differently - to be inclusive and framed around local communities.

The Leeds Health and Wellbeing Strategy – Linking the IGS will encourage partners to use their influence as commissioners and employers to promote apprenticeship opportunities and to support mechanisms which assist people into and back to work.

Children and Young People at the heart of the IGS – Linking the IGS will ensure it looks at achievement and resilience to enable young people to be work ready and able to influence their careers. Support for vulnerable learners and young people with learning difficulties was also highlighted with input welcomed from health partners to support the work already being done by LCC to support these groups. Additionally, the need to work with schools was identified to ensure that a variety of roles in the jobs market are promoted to support aspiration and ensure that young people are given opportunities. Giving children and young people the opportunity to meet adults from a variety of skilled jobs was also suggested to support their future choices. There was also recognition for the need to work closely with employers to match young people with the right opportunity; apprenticeships were not the answer for all communities – this was identified as a proposal which health and care partners could support. Equally, work with parents was key to ensuring a ‘can-do’ attitude and support amongst the whole family.

Links to the Leeds Health & Care Plan – Linking to IGS will ensure there is a coherent vision and will join up some of the big ideas with community cohesion and neighbourhood work.

Consideration of the ‘Social Charter’ – This will provide information on what action is already being taken by Leeds’s Third Sector to support people back into work.

Future Action Planning - It was noted that an IGS Action Plan was being developed, informed by the consultation so far, and would be presented early in 2018. The Action Plan would reference commitments and pledges by partners. The Board noted and welcomed the offer made by Julian Hartley on behalf of Leeds Teaching Hospitals Trust to commit to the Inclusive Anchors Programme.

In conclusion, the Board supported the IGS and the development of the Action Plan noting the opportunity for the Board and its partners to influence the wider economy and suggested the following be considered;

- Inclusion of specific targets and priorities that partners could progress (such as reducing poverty, number of people with disabilities in employment) and targets that are place based and ensure inclusivity
- The need to clearly connect to the Leeds Health and Wellbeing Strategy
- The Action Plan to reflect the needs of Leeds most vulnerable communities

RESOLVED -

- a) To note work done to broaden the understanding of health issues in the economic development world and the understanding about the importance of a strong economy in the health and care system.
- b) To approve subsequent closer alignment of the Health and Wellbeing and Inclusive Growth strategies
- c) To seek to ensure broader health input from both commissioners and providers into the Inclusive Growth Strategy via programmes such as

Inclusive Anchors, Leeds Academic Health Partnership and the impending Innovation District and Nexus projects.

40 Making a breakthrough: a different approach to affect change

The Board considered a joint report providing an overview of the approaches taken to address challenges relating to three Breakthrough Projects with very clear links to the priorities of the Leeds Health and Wellbeing Strategy and the wider determinants of health and wellbeing: supporting the inactive to become active, air quality, and domestic violence and abuse.

The report provided the Board with an opportunity to discuss and explore the challenges related to the issues; to provide a view on what else could be done to ensure links with Leeds's other strategic plans and to consider individual or collective action that can contribute to improved outcomes for people in Leeds.

1. Supporting the Inactive to become Active – In presenting the report, Anna Frearson (Consultant in Public Health) and Mark Allman (Head of Sport & Active Lifestyles) encouraged discussion on:

- How to reduce sedentary behaviour in staff as well as residents. As representatives of large employers/organisations how to encourage physical activity and/or exercise which was acknowledged as being beneficial to work and home wellbeing.
- Meeting the challenge of what else can be done to embed support for physical activity in terms of the workplace, built environment and infrastructure

The Board acknowledged the relationship between activity, mobility, health, mental health and work and made the following comments:

- Leeds Teaching Hospitals NHS Trust staff had responded well to health and wellbeing training, challenges, etc. and the use of sustainable travel transport schemes. Extension of the Leeds Cycleway to link St James's and the Leeds General Infirmary was identified as an additional measure to further encourage activity.
- A campaign of information and signposting on the location of cycle paths, walkways and bridleways was identified as a measure to increase their use; alongside information on cycle safety.
- Recognition of the need to link to Mindful Employer measures.
- Acknowledged that Leeds West NHS CCG was committed to factoring in physical activity in its approach to commissioning pathways of care, particularly for musculoskeletal disorders; and the commitment to build this into health coaching and Making Every Contact Count policies.
- Recognition of concerns for the health of some health & care sector staff, particularly community health staff, who were physically inactive due to the nature of their work which required them to drive between appointments and impacted on their diet as well as their ability to be active.
- The need to consider any cultural or behavioural issues which may prevent people from taking up physical activity and to consider how individual communities provide their own activities. It was noted that

the Third Sector had a key role to play in being able to provide information on what is provided throughout Leeds own communities.

- The role of education – through schools, health visitors and parents to encourage physical activity.
- Whether ‘physical activity’ could be promoted through; and encourage wider involvement in; the Leeds Health & Care Plan, noting that any campaign would need to be sustainable with a long term commitment

The Board noted the intention for further discussions between the Chief Officer, Health Partnerships and the Head of Sport & Active Lifestyle on a collective approach to this Breakthrough Project.

RESOLVED -

- 1) To note the discussions on the contribution that physical activity and moving more can make to the city’s priorities;
- 2) To note the comments and pledges made during discussions outlined above in terms of how to contribute to increasing physical activity including:
 - As commissioners – how to integrate physical activity into health and care pathways and services.
 - As employers – how to upskill staff to better support people to become active and commit to creating workplaces that support staff to become more active / less sedentary (including active travel to work).
 - As collective leaders – how to develop a whole systems approach to physical activity in Leeds in relation to improving collaboration and the sharing of resources between partners.
- 3) To note the comments made during discussions which provide views on the role of the HWB in terms of new governance structures that will be put in place for Sport Leeds and the new Sport and Active Lifestyle Strategy; to better reflect the positioning of Physical Activity in the City and focus on decreasing inactivity levels
- 4) To note the intention for discussions to be held between the Chief Officer, Health Partnerships and the Head of Service for Sport & Active Lifestyle on a collective approach to this Breakthrough Project which will further the consideration of the matters outlined in points 1 to 3 above.

2. Air Quality – Andrew Hickford (Project Manager, Resources & Housing) and Dr Ian Cameron (Director of Public Health) presented this section of the report, and sought to encourage discussion focussing on the role of health organisations in transport, the use of use of air pollution information to inform the public and providing advice and guidance on the link between air pollution and health to health professionals.

The following issues were highlighted:

- The Department for the Environment, Food and Rural Affairs had recommended the use of Clean Air Zones (CAZ) in Leeds to tackle pollution, with 4 key roads requiring action. A further report would be

presented to the Board for consultation once CAZ areas are determined.

- Important to note that most of Leeds maintained good air quality
- Air pollution in Leeds contributed to 680 deaths annually and was a factor in the number of recorded cases of respiratory; lung and Chronic Ventricular Diseases
- The public's attitude towards air pollution showed that in general, more people were concerned about the impact of air pollution on asthma, than its impact on cancer.
- The link between fuel poverty and health. It was noted that Leeds had 70,000 Victorian era homes, which were expensive and difficult to insulate and upgrade to modern effective, heating systems
- Affordable warmth was very important for good health. Community nurses often came into contact with patients in cold homes and the offer of close working and support between health organisations was welcomed to tackle fuel poverty and provide information to residents and staff on the opportunities available to them to improve air pollution and reduce fuel poverty.
- Both Leeds Community Healthcare NHS Trust and Leeds and York Partnership NHS Foundation Trust representatives expressed an interest in closer working with Leeds Teaching Hospitals NHS Trust to see the work being done there in terms of the vehicle fleet and reducing individual air pollution.
- Important to reiterate that cycling in high polluted areas was still better than being in a car
- In response to a query about how to encourage wider use of electric cars, a number of measures were identified; including parking permits for electric vehicle owners/users which grants free on-street parking and use of LCC car parks; and grant funding was available for electric charging point installation. Further information on this would be sent directly to Board members and partners to encourage consideration of electric vehicle use. Acknowledgement that despite the work already done in Leeds, the need to increase uptake in public transport and active travel whilst reducing the number of private vehicles entering the city centre still remained

RESOLVED -

- 1) To provide advice and guidance on how best to link through to the city's health professionals to promote key messages on air quality.
- 2) To encourage the city's health organisations to lead by example in terms of their own fleet and travel planning.
- 3) To consider how best to utilise air pollution data to support vulnerable groups
- 4) To participate in the air quality consultation process and to commit to provide input in to the Leeds Transport Conversation
- 5) To support an integrated independent living and affordable warmth service to ensure that vulnerable people receive physical improvements to their homes that will allow them to be warm and well at home.

- 6) To champion affordable warmth across the health and social care sectors, to ensure that trusted frontline carers continue to refer clients for support.
- 7) To consider new joint investment in energy efficiency improvements for particularly vulnerable residents where there is a health business case (i.e. to improve hospital discharge processes).

3. Domestic Violence and Abuse – Michelle de Souza presented this element of the report, seeking consideration of the impact of domestic violence and abuse on health and wellbeing; mental health and cost to services. She reported that Leeds was regarded as being at the forefront of DV work, with good links operating between adult social care, midwifery services and Accident & Emergency departments. However key challenges for the future were development of the workforce; consideration of how to deal with perpetrators of domestic violence and the scale of the issue – with approximately 19,500 domestic violence related calls to West Yorkshire Police recorded last year. Other key issues to note included;

- Serious Case Reviews often revealed social isolation as a recurring theme in cases
- When dealing with case reporting; using family members to translate could prevent a victim from reporting the full details
- Not all victims report to the police in the first instance, as some may feel safer in other settings.

It was noted that LCC Department of Children and Families sought to employ a multi-agency partnership to support affected families, with a scheme in place to support the children of the family. The Board further discussed:

- Whether the definition of domestic violence included Female Genital Mutilation. It was noted that this had been considered as part of the DV Breakthrough Project but was not a key focus of the Leeds Health and Wellbeing Strategy. As a safeguarding issue, several sectors within the health & care sector received awareness training with health professionals being duty bound to report cases. However it was acknowledged that victims may not know how to access support. The Board further noted the offer from the representative of NHS England to provide a co-ordination role in order to prevent a fragmented support system.
- Understanding of what 'safe' means is different and based on cultural experiences. Part of domestic violence support work must be about clearly explaining rights, expectations, etc. across the Leeds community
- Reference was made to the Making Every Contact Count initiative, noting that this was being rolled out across the city.
- Raising awareness was identified as key to tackling the issue

In terms of identifying measures that the health & care sector could undertake to capture and identify cases the following comments were noted:

- To consider the long term impact of what children or others have witnessed in a DV environment

- To seek to encourage more primary care, GP practices and health & care settings to introduce a routine domestic violence enquiry as a general rule.

RESOLVED -

- 1) To note the contents of the report and the comments made during discussions seeking to identify collective action to address persistent challenges:
- 2) To continue to identify opportunities to increase capacity at the Front Door Safeguarding Hub.
- 3) To seek to identify new opportunities to upskill staff and services to identify and respond to Domestic Violence and in particular issues of coercion and control
- 4) To remove barriers and improve access to appropriate services for people with complex needs who are experiencing domestic violence
- 5) To continue to consider ways to increase services and interventions available to perpetrators of domestic violence
- 6) To continue to consider opportunities to tackle issues of social isolation as a barrier to addressing issues of domestic violence and abuse.

41 For Information: Leeds Health and Care Quarterly Financial Reporting

For information, the Board received the report from Leeds Health and Care Partnership Executive Group (PEG) which provided an overview of the financial positions of the health & care organisations in Leeds, brought together to provide a single citywide quarterly financial report.

RESOLVED - To note the Leeds health & care quarterly financial report the end of year forecast.

42 For Information: iBCF (Spring Budget) and Better Care Fund 2017/18 Quarter 2 Returns

The Board received for information, a copy of the iBCF Spring Budget and the Better Care Fund 2017/18 Quarter 2 returns.

RESOLVED

- a) To note the contents of the Leeds iBCF Quarter 2 return to the DCLG
- b) To note the content of the Leeds HWB BCF Performance Monitoring return to NHSE for quarter 2 of 2017/18

43 For information: Brief Overview of Delayed Transfers of Care and Non-Elective Admission in Leeds

The Board received a joint report for information from the Chief Officer Resources & Strategy, LCC Adults & Health and the Director of Commissioning, Strategy & Performance, NHS Leeds CCGs which provided a brief overview of Delayed Transfers of Care (DTOC) and non-elective admissions

Sara Munro, Leeds and York Partnership NHS Foundation Trust, reported that as part of the ongoing work to ensure that the data sets provided are achievable and give an accurate baseline; a correction had been identified. The Board supported the suggestion that a letter be submitted from the Health & Wellbeing Board to NHS England to challenge the current baseline and include support for a revised baseline for Leeds. It was agreed that a letter

would be drafted and circulated for comments from members prior to its submission.

RESOLVED -

- a) To note the definition of Delayed Transfers of Care (DTOCs).
- b) To note the impact on the system of high levels of DTOCs.
- c) To note the level of improvement required to deliver the 3.5% iBCF target.
- d) To note the challenges and risks faced by the Health and Care System partners in Leeds associated with delivery of the agreed iBCF trajectory.
- e) To note issues associated with DTOC baselines and trajectories with assessment of position and proposed approach to changes to be reported back to HWB.
- f) To note the intention for a letter to be submitted to NHS England from the Health & Wellbeing Board challenging the current data baseline and including support for a revised baseline for Leeds. A draft letter will be submitted to Board Members for comment prior to submission to NHS England.

44 For Information: Pharmacy Needs Assessment 2018-21

For information, the Director of Public Health submitted a report providing the Board with an update on three issues:

- The current status of the 2018-21 Pharmacy Needs Assessment
- An early indication of the findings of community pharmaceutical services across Leeds and highlight any gaps that have become evident at this stage of the work.
- Notes that the Pharmacy Needs Assessment will be placed on the Leeds Observatory website for a period of 60 days from 4th December 2017 to 2nd February 2018.

RESOLVED -

- a) To note that the Pharmacy Needs Assessment is on track and progressing to consultation stage.
- b) To note that the Pharmacy Needs Assessment will be placed on the Leeds Observatory website <http://observatory.leeds.gov.uk/> for a period of 60 days for public consultation from 4th December 2017 to 2nd February 2018.
- c) To note that the updated Pharmacy Needs Assessment will be brought to the Health and Wellbeing Board on 19th February 2018 for final approval and sign off, ready for publication by 1st April 2018.
- d) To note the measures to be taken to address the gaps identified so far.

45 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next meeting as Monday 19th February 2018 at 10.00 am (with a pre-meeting for Board members at 9.30 am)

Leeds Health and Wellbeing Board



Report author: Holly Dannhauser
(Health Partnerships Manager)

Report of: Chief Officer Health Partnerships

Report to: Leeds Health and Wellbeing Board

Date: 19 February 2018

Subject: Leeds Health and Wellbeing Board: Reviewing the year 2017 – 2018

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No
If relevant, access to information procedure rule number:		
Appendix number:		

Summary of main issues

This paper introduces the attached report, which serves as a review of the strategic direction provided by the Health and Wellbeing Board (HWB). It provides an understanding of steps taken and progress made towards the Leeds Health and Wellbeing Strategy from the perspective of partner organisations, those who have brought items to the HWB, as well as HWB members themselves.

The report provides a snapshot in time, summarising just some of the significant work achieved over the last year against the 12 priorities of the Strategy and based on the recommendations of the HWB.

Recommendations

The Health and Wellbeing Board is asked to:

- Discuss the collated findings of this report
- Steer, commission or clarify any future action as appropriate to make further progress towards the outcomes and priorities of the Leeds Health and Wellbeing Strategy
- Identify any further items for the live work plan

1 Purpose of this report

- 1.1 This paper introduces the report attached as an appendix, which takes a look back over the last 12 months of Health and Wellbeing Board (HWB) and partnership activity. It also includes a summary of a self-assessment workshop held for Board members in January 2018 as well as an update on the indicators of the Leeds Health and Wellbeing Strategy.
- 1.2 The attached report serves as a review of the strategic direction provided by the HWB providing an understanding of steps taken and progress made towards the Leeds Health and Wellbeing Strategy. This information will continue to inform the future work planning and focus of the HWB into 2018/19.

2 Background information

- 2.1 The most recent Shared Intelligence report The Power of Place: Health and Wellbeing Boards in 2017 states that 'the most effective HWBs are reasserting the importance of action to address the wider determinants of health. By doing so they are creating a strategic framework to which STPs and action on the integration of health and social care must relate'.
- 2.2 Using this statement (and the wider report) the HWB has been collating information to review its performance and progress over the last 12 months, January 2017 - January 2018.
- 2.3 Each of the organisations represented on the Health and Wellbeing Board has contributed to this review, as well as a range of partners who have interacted with the Board during the last year.
- 2.4 The Leeds Health and Wellbeing Strategy 2016-21 is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. This strategy is our blueprint for how we will achieve that. It is led by the partners on the Leeds Health and Wellbeing Board and it belongs to everyone in the city.
- 2.5 The Strategy provides a set of priorities for everyone in Leeds to contribute to. But it also provides a framework for health and care system leaders to collectively assess whether their work is making a difference to the people of Leeds.
- 2.6 It is important to remember too, that other strategies and action plans will provide further detail on how specific parts of the citywide vision is being achieved.

3 Main issues

- 3.1 The attached report is a summary of information drawn from partner organisations and health and care colleagues. It takes a look at what items have been considered by the HWB, the recommendations made, and updates and actions against these recommendations. A particularly rich source of information comes from each of the partner organisations represented on the HWB, providing their perspectives of progress made towards the Leeds Health and Wellbeing Strategy.

- 3.2 The review of activity indicates how well established the Leeds Health and Wellbeing Strategy has become since its refresh in April 2016. It has served to shape organisation's priorities and activity, has brought people together around common goals, and has reinforce partnership working. Most importantly, it ensures that everything we do aims to positively impact on the outcomes that people living in Leeds experience.
- 3.3 A set of measures was agreed to help identify the success and impact of the current Health and Wellbeing Strategy – current data is contained within the attached report. For the most part these measures are routinely available either in national data releases, including websites, or in local accountability such as through the Leeds City Council's Best Council Plan.
- 3.4 It is important to note that this report will undoubtedly fail to capture the wealth and diversity of work and initiatives in the city that contribute to the Strategy. Therefore, this serves as a summary of highlights, indicative of progress.
- 3.5 The collation of this information was used as a basis for a self-assessment workshop for Health and Wellbeing Board members, held in January 2018. A summary from discussions held at this workshop have been included in the report.
- 3.6 The report includes a great deal of successes and highlights areas where great progress has been made. However, this must be balanced with an awareness of the pressures that health and care organisations, staff and citizens are currently facing.
- 3.7 For health and care leaders, this means making sure there is appropriate support for our valued and valuable front line staff and ensuring that people are actively involved in the design and delivery of services. There is plenty more to do to take further steps towards our shared ambitions. But in doing so, Leeds can rely on a strong leadership, working collaboratively, using shared values to reach our city's goals.
- 3.8 For citizens, the Leeds Health and Wellbeing Strategy recognises that wellbeing starts with people, and everyone has a part to play in making Leeds the best city for health and wellbeing. It is now more important than ever that the wider population consider what we can do to improve our own health and wellbeing, support those around us, or contribute to the environment that we live in.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 The attached report has been produced as a result of an engagement process with all organisations represented on the HWB as well as the lead for every item that has been submitted to the Board in the last 12 months. Additionally, the HWB workshop provided the opportunity for each member organisation to share further views and experiences.
- 4.1.2 The asset-based approach taken in Leeds, which is founded upon principles of 'working with' and looking at what's strong rather than what's wrong, means that

much of the initiatives, programmes and decisions included in the report are firmly based on staff and citizen engagement.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 The work of the HWB (as included in the report) is guided by the vision of the Leeds Health and Wellbeing Strategy, to improve the health of the poorest the fastest. Consequently, tackling health inequalities is central to achieving the vision through work around the 12 priorities of the Strategy.

4.3 Resources and value for money

- 4.3.1 The report confirms that the HWB works collectively, speaks as 'one system', and aims to spend the Leeds £ wisely. The volume of partnership working reported in the review, including the third sector, is testament to the approach taken by the Leeds health and care system – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long term commitment to financial sustainability.

4.4 Legal Implications, access to information and call In

- 4.4.1 There are no access to information and call-in implications arising from this report.

4.5 Risk management

- 4.5.1 Risks relating to individual programmes cited in the review are managed by their relevant organisations as part of standard risk management procedures.

5 Conclusions

- 5.1 In reviewing the work and influence of the HWB in the context of the Leeds Health and Wellbeing Strategy, it is clear that 2017-18 has seen the HWB reassert its focus on the wider and social determinants of health, whilst emphasising its role in locally shaping the future of health and care services. Providing a space where health and care leaders come together to have productive and sometimes challenging conversations has bolstered partnership working in and for the city and influenced a wide range of initiatives. There is more to do and the HWB is identifying areas of stretch through its ongoing work plan. Therefore, assessing the Board in light of 'The Power of Place' definition means we can conclude that Leeds does have an effective HWB.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Discuss the collated findings of this report
- Steer, commission or clarify any future action as appropriate to make further progress towards the outcomes and priorities of the Leeds Health and Wellbeing Strategy
- Identify any further items for the live work plan

7 Background documents

- 7.1 The Power of Place: Health and Wellbeing Boards in 2017
<https://www.local.gov.uk/sites/default/files/documents/The%20power%20of%20place%20health%20and%20wellbeing%20boards%20in%202017.pdf>

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How does this help reduce health inequalities in Leeds?

The work of the HWB (as included in the report) is guided by the vision of the Leeds Health and Wellbeing Strategy, to improve the health of the poorest the fastest. Consequently, tackling health inequalities is central to achieving the vision through work around the 12 priorities of the Strategy.

How does this help create a high quality health and care system?

Undertaking a review of the HWB enables understanding of where the Board is functioning effectively and where improvements can be made. The Board is clear in its leadership role in the city and the system, with clear oversight of issues for the health and care system.

How does this help to have a financially sustainable health and care system?

The review summarises some of the initiatives that are funded by our public and third sector organisations in the city. Often these are delivered in partnership, for shared outcomes, or in a way that reduces or removes duplication. The HWB also receives a quarterly summary of the citywide health and care financial position, increasing transparency and understanding of financial pressures and solutions as 'one system'.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21

A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

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Leeds Health and Wellbeing Board

Reviewing the year

2017 – 2018





Foreword

By Councillor Rebecca Charlwood
Chair of Leeds Health and Wellbeing Board



The last year has been one of significant progress, equally matched by distinct health and care challenges for partners, staff and citizens. For the Leeds Health and Wellbeing Board, this has meant continuing to work closely together, as if we were one organisation, to speak openly and honestly, to share our successes, and make best use of resources to meet the challenges we face.

Achieving consistently high quality care for everyone, responding to demographic change and achieving long-term financial sustainability across the health and care system means we must do things differently. But whilst new ways of working ensure Leeds is well placed to achieve its ambitions, it's not without difficulties. National and local pressures mean there is no doubt that this is a tough time for our health and care staff at all levels.

But Leeds is rising to these challenges and we have huge amounts working in our favour; our decision making bodies are working more closely than ever before; we have a thriving third sector and inspiring community assets; we have clear ideas of what change is needed and steps are made with collective action. Most importantly, however, we have you – the citizens of Leeds. You have an important part to play in helping the city achieve its ambition to be the best city for health and wellbeing.

These assets and strengths are reaping great rewards and Leeds now ranks highest amongst the Core Cities according to recently released analysis from the What Works Centre for Wellbeing. This is testament to the hard work, dedication and commitment to excellence across our city. These results clearly reflect our approach to 'working with' others to create effective and local solutions that really work.

Our Health and Wellbeing Strategy continues to guide the way we work to ensure we create the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Its reach, influence and credibility has grown significantly over the last year - locally our health and care partners use it to prioritise work and test

progress, but the Strategy has also been shared with health and care colleagues as far as Norway and Japan.

The Health and Wellbeing Board has taken a number of steps to further progress towards the Strategy's five outcomes and twelve priorities. Many of these are captured below, with progress reported against more than 30 sets of recommendations made over the last 12 months. These cover a wide range of topics, considering action to support and work with some of our most vulnerable communities.

The quality of the Board's conversations cannot be underestimated. Tackling broad and challenging topics has demonstrated the strength of the partnership and played a crucial role in driving action, integration and engagement.

2017 has seen the Board reassert its focus on tackling the wider and social determinants of health, whilst influencing and overseeing planning for the future of health and care services and ensuring effective engagement with partners, staff and citizens.

Throughout the year the Board has had oversight of the Leeds Health and Care Plan, making sure partners, politicians and citizens shape the design and delivery of services. We've been well sighted on and influenced the winter planning process, resulting in an accompanying clear narrative explaining plans and proposed changes. A Safer Leeds representative has joined our membership and we now hold as many of our meetings as possible in community venues.

As well as rounding up the Board's recommendations, this report also captures progress made towards the Strategy by partners represented on the Board. But this is only part of the story of our Health and Wellbeing Strategy. The invitation still stands for you to play your part in making Leeds a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

Introducing...

The Leeds Health and Wellbeing Board

What is the Leeds Health and Wellbeing Board?

The Health and Wellbeing Board (HWB) is a group of senior representatives from organisations across Leeds, including Leeds City Council, the NHS, the community sector and Healthwatch, which represents views of the public. There is cross-party political representation, with meetings Chaired by the Executive Member for Adults, Health and Wellbeing.

The Health and Wellbeing Board helps to achieve our ambition of Leeds being a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest. The Health and Wellbeing Board works collectively, with the strengths and assets of Leeds people, to oversee, influence and shape action to ensure Leeds is a healthy city with high quality services.

The Board has been meeting since April 2013 and was set up as part of a national policy, called the Health and Social Care Act.

Members

There are 21 members of the Health and Wellbeing Board; some are mandatory appointments to adhere to the national requirements for all Health and Wellbeing Boards and some are additional members.

Why does the Health and Wellbeing Board exist?

The Health and Wellbeing Board creates the space for senior leaders to come together to develop strategic oversight and direction for health and care.

In Leeds, the Board takes a place-based approach to tackling the 12 priorities set out in the Leeds Health and Wellbeing Strategy 2016-21 and, through collective leadership around a shared vision, sets the direction for our city to reach its 5 outcomes.

The Board has a relentless focus on reducing health inequalities and creating a high quality and sustainable health and care system.

The Leeds Health and Wellbeing Strategy 2016-21

Our Health and Wellbeing Strategy sets out our vision for Leeds and is our blueprint for how we will achieve that.

So many factors contribute to our health and wellbeing, meaning our challenge is to reflect the breadth of the agenda, whilst being specific about the areas we need to focus on to make the biggest difference. The Health and Wellbeing Board's work plan has helped guide our collective activity, as well as the work going on in our individual organisations. The updates captured in this report aim to demonstrate progress towards the 12 priorities of the Strategy, supporting our statement of intent that:

In Leeds, as we grow up and as we grow old, the people around us, the places we live in, the work we do, the way we move and the type of support we receive, will all help keep us healthier for longer. We will build resilience, live happier, healthier lives, do the best for one another and provide the best care possible to be the best city for health and wellbeing.

Vision:

'Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest'

Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:

'Leeds will be the best city for health and wellbeing'.

And a clear vision:

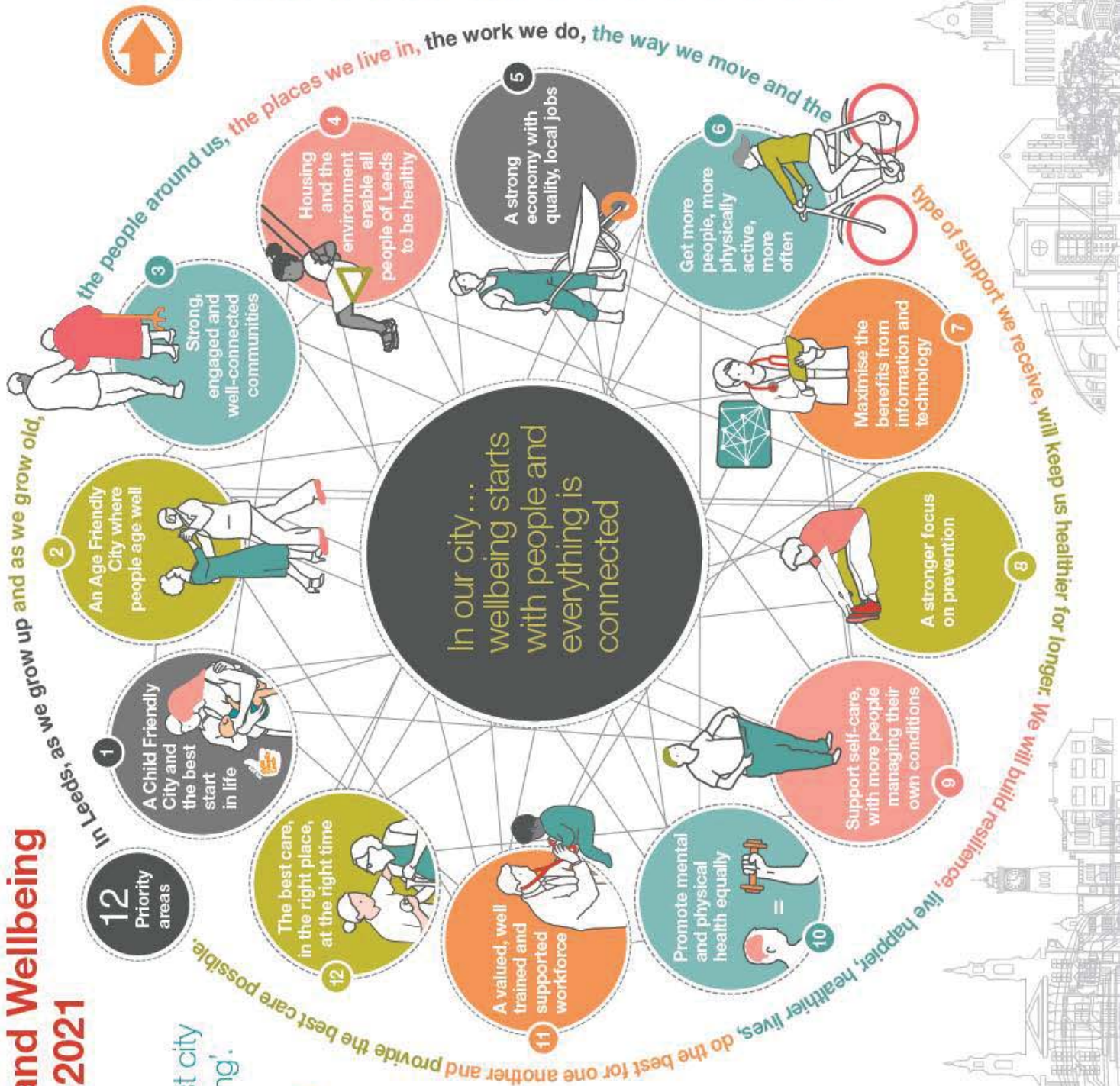
'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.

5 Outcomes

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

Indicators

- Infant mortality
- Good educational attainment at 16
- People earning a Living Wage
- Incidents of domestic violence
- Incidents of hate crime
- People affording to heat their home
- Young people in employment, education or training
- Adults in employment
- Physically active adults
- Children above a healthy weight
- Avoidable years of life lost
- Adults who smoke
- People supported to manage their health condition
- Children's positive view of their wellbeing
- Early death for people with a serious mental illness
- Employment of people with a mental illness
- Unnecessary time patients spend in hospital
- Time older people spend in care homes
- Preventable hospital admissions
- Repeat emergency visits to hospital
- Carers supported





Making a difference

Our individual and collective contribution

About this report

This report serves as a roundup of activity commissioned or directed by the Health and Wellbeing Board and guided by the Leeds Health and Wellbeing Strategy. It covers the time period of January 2017 to January 2018 and is constructed from perspectives of the organisations represented on the Board, actions and updates from those who have brought items to the Board over the last year, and self-assessments of the Board's function and purpose from Board members.



Progress towards the Leeds Health and Wellbeing Strategy

This Strategy's outcomes, priorities and indicators gives us a framework to test out whether the work we do is making a difference. How we as Board members view our progress is also an important factor in reviewing the way we work together for the people of Leeds. This report also helps capture how other strategies, action plans and projects are helping to achieve specific parts of the citywide vision. It is clear that there is a huge amount going on within organisations and by partners working together and working with citizens. Therefore, much of what is provided here is just a snapshot of activity that contributes towards the Leeds Health and Wellbeing Strategy 2016-21.

HWB agenda items aligned to priorities

To ensure that the HWB has a relentless focus the priorities set out in the Leeds Health and Wellbeing Strategy 2016-21, report authors are asked to identify which priorities their items align to. The graph below shows how the 21 public items considered by the Board in 2017 are aligned.

Number of public HWB items aligned to priorities



Progress towards the Leeds Health and Wellbeing Strategy



**Collated from the organisations
represented on the Health and
Wellbeing Board**



The best start in life provides important foundations for good health and wellbeing throughout life. This means the best start for every Leeds baby from conception to age two, providing high quality, joined-up maternity and antenatal care guided by the mother's needs for supported families, strong attachments and positive infant wellbeing. It means ensuring solutions are coordinated around needs and assets in families and the wider community.

Highlights from the last 12 months include:

- Progressing strategies in partnership e.g. Future in Mind Strategy and the 5 year Maternity Strategy resulting in improvements in mental health and maternity pathways
- Community midwifery teams aligned with health visiting and children centre teams
- Support for Positive Behaviour Service via Spring Budget Monies
- Further developing inter-generational work, e.g. connecting a nursery with a care home
- Best start is now a recognisable brand following the development of a logo and resources
- North of England Breast Feeding Impact Study gives access to support before other areas
- Tooth decay amongst children in Leeds continues to decrease Delivered in partnership with Children and Families (detailed above)
- Progressing strategies in partnership e.g. Future in Mind Strategy and the 5 year Maternity Strategy resulting in improvements in mental health and maternity pathways
- CCG investment in most deprived areas increased knowledge of infant mortality risk factors
- Recognised offers for health visiting (outstanding" status in terms of the UNICEF Baby Friendly Initiative), school nursing and infant mental health services (outstanding award)
- Community midwifery teams and health visiting (early start) aligned and with named obstetrician
- Work to safeguard and be inclusive e.g. for children with disabilities and reduction in waiting times for speech and language therapy for children over the summer
- Ensuring access to services e.g. chosen place of birth and initiatives e.g. baby box
- The HAAMLA service provides support for pregnant women, and their families, from minority ethnic communities, including asylum seekers and refugees
- The NSPCC pregnancy in mind programme is now a local, standard offer
- Healthwatch Leeds undertook user engagement on their experience of the Health Visiting service in November 2017 to bring local people's voices to influence provision and possible commissioning





We want Leeds to be the best city in the UK to grow old in. Being an Age Friendly City means promoting ageing positively and maximising opportunity for older people to contribute to the life of Leeds. We must build on the strengths of older people and recognise first and foremost their roles as employees, volunteers, investors and consumers. Our built environment, transport, housing must all promote independence and social inclusion.

Highlights from the last 12 months include:

- Investment, commissioning activity and partnership working in areas to support older people e.g. falls prevention, 'Time to Shine', Neighbourhood Networks, cancer diagnosis, dementia support
- 10 health grants in this priority area
- Refresh of Better Lives Strategy
- The Think Delirium Initiative is helping us identify patients at risk of/showing signs of delirium
- Partnership projects e.g. Ageing Well Breakthrough Project, partnership with Centre for Ageing Better, and engagement in Eurocities Urban Ageing Network - covering housing, transport, environment, social inclusion, employment, learning and skills
- Around 100 people referred this year through the Falls Prevention Programme and over 100 organisations have signed up to Winter Friends
- Partnership with LCC connecting people and communities to services that support people and families living with dementia - 45 Memory Cafes, 13 singing groups, and Memory Support Workers integrated into GP practices, Neighbourhood Teams and specialist Memory Services
- Citywide partnerships in initiatives e.g. frailty unit, health coaching, third sector partnerships
- Ensuring better access and appropriate support through Live well Leeds, Physio First, Stroke ESD, and rehabilitation programmes for diabetes, CHD and respiratory
- A lead nurse for older people coordinates work to improve care of older patients across the Trust
- We actively screen patients attending for surgery to identify those with frailty risk factors
- Approx. 3610 activities were provided to reduce social isolation, with Neighbourhood Networks and the Time to Shine programme delivering a huge number of volunteer hours
- New partnership between Leeds City Council, Leeds Older People's Forum (LOPF) and the Centre for Ageing Better furthers our city's commitments
- Review and publication of people's experience of homecare to inform providers and commissioners on quality and delivery with action plans
- Spot checks on care homes – report published
- Engagement on supported housing – user experience Dec 17 to Feb 18

Strong, engaged and well-connected communities



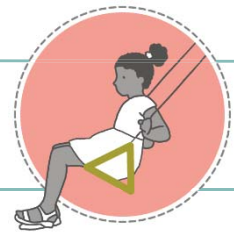
The relationships and resources in communities are building blocks for good health. Leeds has brilliant and diverse communities, well-established neighbourhood networks and a thriving third sector. There are vulnerable groups and areas of the city which experience health inequalities, including people in poverty, migrants, refugees and asylum seekers, the homeless and people with disabilities. People's health outcomes can also depend on specific characteristics, such as ethnicity, gender and sexuality, amongst others. Carers are also crucial to our communities.

Highlights from the last 12 months include:

- Connecting primary care to local communities and invested to improve a wide range of patient and public engagement structures, mostly via the role of 'champions' and participation groups
- 77 grants across 50 third sector organisations reaching 20,000 people living in Leeds through the Leeds CCGs third sector health grants programme
- Continued development of ABCD approach and initiatives to use community strengths
- Funding arrangements e.g. Ideas that Change Lives, Neighbourhood Networks
- Joint work with Financial Inclusion Team on Problem Gambling recognised as innovative good practice by PHE and working with a national lead on the issue
- 'Better Together' community-based health and wellbeing activities across the 10% most deprived areas in Leeds in partnership with third sector has engaged over 7000 people
- Progressing strategies in partnership e.g. Future in Mind Strategy and providing community support
- LYPFT led partnership work in research, action planning and programmes of development to improve pathways and staff knowledge and practice
- Strong engagement across services and with partners to ensure people are at the heart
- Strong patient and public engagement in our services e.g. Leeds Children's Hospital Youth Forum, 25,000 people engaged in medicine for members, significant social media following
- Range of third sector organisations piloting asset-based community development approaches
- Memory Support Workers won Working in Partnership Award and nominated for HSJ award
- Events supporting people with disabilities e.g. 2nd annual conference on Co-production delivered by Touchstone and Leeds Learning Disability week
- Continue to extend networks in local communities and share engagement opportunities



- Annual stakeholder events to raise awareness on a specific topic: "Good Endings" on people's information, choice and support needs when life expectation is limited October 2017
- Chair and co-ordinate People's Voices Group with an aim for better reach to people and communities and consistent shared engagement
- Using health visitors as important community link to other services



To be a healthy city, our environment must promote positive wellbeing. This means Leeds houses are affordable, warm, secure, and support independent living. Green space, leisure provision and walking and cycling opportunities promote health and happiness. Areas of Leeds with the lowest overall green space provision are predominantly inner city, high density housing areas. Considerations about future growth must consider health inequalities and ensure adequate provision.

Highlights from the last 12 months include:

- 2016/17, saw 3,306 new/converted homes and nearly 2,000 empty homes back in use
- A 63% decrease on landfill is estimated compared to 2015/16
- Strategies and initiatives to improve and develop local housing offer e.g. £30m for Development of Extra Care, Homeshare pilot
- 50% reduction in Residential & Nursing Placements for Working Aged Adults
- Steps to implement our environmental strategy include having one of the greenest NHS fleets in the country and taking part in Clean Air Day campaign
- A number of initiatives across the sector provide support, particularly in diverse and/or deprived areas of the city e.g. Healthy Lives Healthy Homes
- Close partnership working on a range of health and wellbeing factors e.g. housing and environment and vulnerable elderly people, fuel poverty



A strong economy with quality local jobs



A good job is really important for good health and wellbeing of working age people. Reducing social inequalities means creating more jobs and better jobs, tackling debt and addressing health related worklessness. With collaboration across private, public, academic and community organisations, Leeds is perfectly placed to be a great location for health innovation. We must also recognise that health and care organisations employ a huge number of people in the city.

Highlights from the last 12 months include:

- Improving standards e.g. Ethical Care Charter, 'Leeds Living Wage' amongst care providers
- Above inflation Fee uplifts for Care Homes/Home Care providers for local sustainability
- Partner in Health and Work Outcomes project, with focus on disabled people and employment
- Fastest private sector jobs growth of any UK city in recent years, amongst highest rates of business start-ups and scale-ups, a top five UK tourism destination (over 26 million visitors a year), and Lonely Planet names Leeds in top 10 European destinations for summer 2017
- Business rate growth increased 0.93% (compared with the 2012/13 baseline) and the regeneration of Leeds' South Bank is making good progress. The size of the city centre will double and the scheme aims to provide over 35,000 jobs and 4,000 homes
- Ensuring a developed workforce with good opportunities e.g. new roles including apprenticeships, integrating nursing workforce, Living wage employer, recruitment processes
- Working with partners to plan and progress towards the Innovation District
- Committed to principles of inclusive growth as an anchor institution and supporting the digital eco system and integration agenda through development of our electronic care record PPM+
- Third sector employment and recruiting volunteers in areas with greatest health inequalities
- Initiatives in place to support people with autism and learning disabilities into work e.g. Supported Internship Programmes and apprenticeships

Get more people, more physically active, more often



We want Leeds to be the most active big city in England. If everybody at every age gets more physically active, more often, we will see a major improvement in health and happiness. We can reduce obesity, improve our wellbeing, become more socially connected and recover better from health problems. One in five adults in Leeds is inactive. As a general rule, the more we move, the greater the benefit. The biggest benefit will be for those who are currently inactive.

Highlights from the last 12 months include:

- Funding of Conservation Volunteer Project from Spring Budget monies
- Working with Sport and Active Lifestyles to develop Healthy Living Centre in East Leeds
- Physical activity levels in primary and secondary age continue to rise with involvement in the 'Active Schools' partnership meaning local, regional and national initiatives. Enhanced PE and sport premium planned for 2018
- Working on the physical activity workstream of the breakthrough project together with Sport and Active Lifestyles, planning, regeneration, transport, parks and countryside
- Promoting the Active 10 campaign in partnership with Public Health England in 2017
- LYPFT healthy living service provides support around physical activity as well as healthy lifestyle, diet, etc
- Initiatives to support the workforce (e.g. challenges and gym benefits) and for citizens (e.g. Live Well Leeds, investing in diabetes education team)
- Increasing physical activity for staff through staff gym and provide exercise classes and active travel promotion



- Promoting challenges for staff and citizens e.g. the NHS 1000 miles campaign
- A wide range of third sector partnership/community programmes from gardening to wellness groups
- Healthwatch promotes the messages to staff, volunteers and via networks and their office base has cycling storage, showers and running club

Maximise the benefits of information and technology



New technology can give people more control of their health and care and enable more coordinated working between organisations. Joined-up information enables people to tell their story once and choose the channel they use to communicate. We want to make better use of technological innovations in patient care, particularly for long term conditions management. This will support people to more effectively manage their own conditions in ways which suit them.

Highlights from the last 12 months include:

- Integrating and using digital solutions across organisations to make savings and increasing users e.g. 25 % increase (to 5000) users of the Leeds Care Record
- Templates within electronic patient records have been developed for use by primary care
- Partner in implementation of digital solutions e.g. Activeage (Samsung) and Telecare (Tunstall) and capital resources prioritised for integrated health and care IT solutions
- Continued development of nationally acclaimed Leeds Care Record
- LYPFT has deployed public wireless internet access across all buildings in the Trust
- Full implementation of Electronic Patient Record in neighbourhood teams
- Development of apps in Early Start, CAMHS and ICAN
- Continued development of digital initiatives e.g. Leeds Care Record, and electronic prescribing rollout (which reduced the number of medicine related incidents across the Trust) as well as new projects e.g. Scan for Safety technology
- Creating and promoting websites/apps e.g. MindWell, Safe Places app
- CCGs funded post at Forum Central researching use of the data by the health and care third sector
- Stakeholder in the Citywide Communications Group, Digital Literacy and Health Information for Patients Groups



A stronger focus on prevention



Targeting specific areas can make a really big difference to preventing ill health, such as obesity, smoking, and harmful drinking, as we. Cancer prevention, early diagnosis and successful therapy will reduce inequalities and save money. Focusing on these issues requires a whole-city approach to help people remain healthy and independent for longer. Local and regional partnerships protect the health of Leeds' communities around infection prevention and control, and environmental hazards such as air quality and excess seasonal deaths.

Highlights from the last 12 months include:

- The CCG is re-evaluating resource allocation to promote preventative, safeguarding and proactive care services, as well as investing in local initiatives. These are complemented by revised policies and processes
- 20 health grants support this priority
- Range of initiatives to increase support services e.g. Community Bed Strategy, Reablement, Telecare 'Smart rooms' as well as Dementia information and advice
- A wide range of strategic (e.g. NHS Winter Plan, improved pathways, planning policies) and operational preventative measures (e.g. 10,000 people attending an NHS Health Check in 6 month period, 4391 people referred to National Diabetes prevention programme, reduction in smokers to 17.8%, One You Leeds launched, reduction in seasonal deaths)
- Raising awareness and using champions e.g. cancer, TB, antibiotic resistance, alcohol, flu
- LYPFT re-evaluating resource allocation towards prevention proactive care services - in adult mental health services and for vulnerable groups e.g. homeless, gypsy and travellers
- 20 health grants supported this priority



- Preventative work with patients focuses on falls, pressure ulcers and UTIs and being done with a health coaching approach and changing the conversation
- LTHT have successfully piloted a better value healthcare initiative to ensure patients do not receive diagnostic imaging tests that are not required for their care
- Maintaining existing investment and attracting new funding e.g. Leeds Third Sector Health Grants benefitted approximately 16,000 people, Big Lottery funding awarded, The Leeds Fund impacted 17,406 people – all benefited a diverse range of communities across the city

Support self-care, with more people managing their own conditions



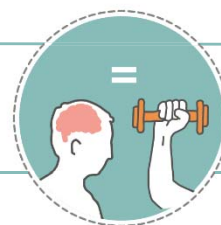
Long term conditions are the leading causes of death and disability in Leeds and account for most of our health and care spending. Cases of cancer, diabetes, respiratory disease, dementia and cardiovascular disease will increase as the population of Leeds grows and ages. This means it is important to support people to maintain independence and wellbeing within local communities for as long as possible. People need to be more involved in decision making, with person-centred care, coordinated around individuals.

Highlights from the last 12 months include:

- Local investment and national funding directed towards this priority, supporting people with a wide range of conditions e.g. respiratory conditions, dementia, diabetes, poor mental health
- 12 health grants support this priority
- Approaches to support self-care e.g. Strengths Based Social Care, 'Better Conversations' and support for carers, consultation on re-design and re-commissioning of Leeds Directory
- "Better Conversations" shortlisted by the HSJ for Local Authority and Health partnership working
- Peer support and increased collaborative care/support planning for long term conditions
- Mindwell website for adults launched in accessible format and getting 5000 hits per month
- LYPFT and LCH jointly improving interface between services, integrating some of the service components with local focus and linked to emerging Local Care Partnerships (LCPs)
- Progressed in partnership with asset-based approaches, across all ages, e.g. piloting self-care teams across neighbourhood teams, integrating nursing teams and long term conditions teams
- The "Sit up, Get dressed, Keep moving" campaign helps people feel more independent, empowered with less loss of muscle strength and quicker recovery
- Initiatives to support those with diabetes including staff changes and training e.g. recruitment for inpatient diabetes, training for practice nurses and structured education for the newly diagnosed
- Unique Improvements launched in the third sector e.g. Cancer Awareness service, Battlescars support groups for people who self-harm, diabetes support groups
- Stakeholder in work programmes on prevention with representation in sub-groups promoting the importance of co-production and early engagement



Promote mental health and physical health equally



Our ambitions for mental health are crucial for reducing health inequalities. Good employment, opportunities to learn, decent housing, financial inclusion and debt are all key determinants of emotional wellbeing and good mental health. Improving mental health is everyone's business. We want to see this led by employers, service providers and communities alongside improved integration of mental and physical health services.

Highlights from the last 12 months include:

- Good outcomes from the CCG continuing to invest in mental health services and initiatives to improve pathways, access and self-management, reducing referrals, including in maternity
- 17 health grants support this priority
- Conservation Volunteers Project supported via Spring Budget Monies
- Re-Commissioning in 2018 of MH Third Sector
- MindMate Champion programme has wide sign up with recruited Ambassadors and social media campaign
- Crisis operational group established and applying for national funding to support creation of a Safe Space for young people in the city
- Regional Time to Change Hub committed to reducing mental health stigma
- 'Leeds in Mind 2017' assessed mental health needs and possible improvements
- Suicide prevention initiatives and bereavement services nationally recognised
- The Leeds approach to working in partnership enables a holistic focus, incorporating both physical and mental health requirements, embedded in the Strategy and the Leeds Plan
- MindMate lessons provide high quality, evidence-based content to reduce stigma and raise awareness of mental health
- LYPFT continued successful service user employment support model with Leeds Mind WorkPlace Leeds with good outcomes
- Development of initiatives to support and promote good mental health e.g. MindMate, children's eating disorder services and reduction in wait times for autistic spectrum disorders
- Nurses employed with both skills sets in key settings, e.g. policy custody suites and CAMHS
- Ensuring supportive environments e.g. dementia friendly wards and services e.g. counselling line for staff, expanded perinatal mental health team
- We have contributed to research into pain management for patients with dementia
- Mental health support e.g. Converge Leeds partnership programme of adult university courses, Time to Change Hub to tackle stigma, Young Dementia Leeds, merge of Volition and PSI Network
- Funding for phase two of LGBT+ Mapping Project, feeding into Mental Health Needs Assessment

A valued, well-trained and supported workforce



Leeds is one of the best places in the UK to work in health and social care. We have a highly motivated, creative and caring workforce, working hard to deliver high quality care. This workforce, many of whom live as well as work in the city, are a huge asset for making change happen. Working as one workforce for Leeds, with shared values and collaborative working, supports joined-up services. The third sector and those in caring and volunteer roles in the community will be crucial to make the most of our city wide assets.



Highlights from the last 12 months include:

- A partnership 'One City' approach to delivering high quality care in care homes.
- Significant investment to develop the primary care workforce through support, advice and training
- 17 health grants support this priority
- New initiatives to support workforce training and development e.g. Health and Care leadership Academy, Integrated Occupational Therapy workforce
- New and innovative work with private sector partners, e.g. John Lewis in their first year in the city
- During 2017, public health has trained 3,859 people from across the wider workforce in Leeds to support them in their health and wellbeing roles
- Involvement in steering workforce development plans through the Partnership Executive Group (PEG) to ensure scope is correct
- Apprenticeship levy offers opportunities to invest in the health and care workforce
- A number of partnership events have demonstrated good cross city working. The second Baby Week, for example was an excellent demonstration of what can be achieved
- LYPFT is paying the foundation for living wage and ranked 34/50 top inclusive employers nationally
- All NHS providers in the city remain committed and signed up to the Mindful Employer standard
- Investments to support workforce and internships to support people LD into employment
- Training and development for staff, including preceptorship programme, alongside OD work around creating a good working life. Staff making Feel Good Pledge offered flu jab (with 75% uptake)
- LYPFT lead role in development of Health and Care Academy
- Staff survey results improved again and new staff supported e.g. apprenticeships and new training programmes (including nursing)
- Initiatives to further integration e.g. training programmes for GP practices/practice nurses, nursing
- Mentally health workplaces with ongoing promotion of Mindful Employer, Touchstone won Top Inclusive UK employer with Community Links in 9th, launch of Leeds Working Carers Initiative
- Healthwatch staff and volunteer development programmes in place



More effective, efficient health and care means moving more services from hospitals to community settings, with services closer to home will be provided by integrated teams. This kind of integration, designed with people at the heart, helps to keep people out of hospital whilst providing care in the most appropriate setting. These teams will be rooted in neighbourhoods and communities, with coordination between primary, community, mental health and social care.

Highlights from the last 12 months include:

- Initiatives to reduce waiting times and bed days, including the development of the partnership A&E delivery plan, investment in community bed capacity, mental health and dementia services
- Investment to increase community bed capacity by 26%
- Commissioning local social prescribing services for citizens
- Improving local access e.g. Integrated Community Based Health and Social Care Teams, Leeds Centre for Independent Living Services (LCIL), Talking Points, Rapid Response, and local pilots
- Redevelopment of learning disability service, Crisis support and health facilitation teams
- “Good” status following CQC inspection with “outstanding” for Caring in adult services
- Range of initiatives offering better support offer e.g. integrated nursing and integrated clinics, extended hours, single points of access services, increase in end of life care and patients dying in their preferred place of death
- The LTHT frailty ensured that 65% people were able to return home rather than be admitted
- Great results from patient quality improvement project e.g. 2017 saw 31% less inpatient cardiac arrests than 2015 and 7% less than 2016
- Continued input, challenge and system leadership into the strategic health and care system and to pilot initiatives on the ground e.g. Age UK Leeds Hospital to Home service
- St Gemma’s Hospice were awarded Outstanding in their 2017 CQC inspection
- Provide an advice and signposting service via telephone, post or email on any health or care issues about Leeds health and care, reporting themes to providers and commissioners
- Co-ordinate and chair a complaints lead group to improve consistency, share handling and improve experience including learning





Roundup of Health and Wellbeing Board activity



Recommendations and progress updates from the last 12 months

January 2017

Workshop session

1. Improving citizen health: what good looks like

Actions for Consideration:

- Health and Wellbeing Board to consider their role as employers and influencers of the workforce by:
 - Signing up to Mindful Employer
 - Ensuring wellbeing of public sector staff (50,000) in the city
 - Holding ourselves, each other and those we commission to account
- Design/develop a viable, local alternative to IAPT and use this as grounds to challenge national policy (maybe in conjunction with other West Yorkshire HWBs)
- Establish neighbourhood networks for young people
- Push for culture change – Health and Wellbeing Board to pull all mental health activity together and determine how resource is used and what our narrative is for the city
- Influence city planners/developers/housing colleagues and exerting pressure to ensure decision making helps to improve the mental health of our deprived communities
- Link this into the prevention strand of the Leeds Health and Care Plan (Leeds Plan)

Update:

In Leeds we are working towards more integrated health and wellbeing, enabling us to focus holistically on physical and mental wellbeing requirements of citizens. An action plan has been created and progressed, linked to the Leeds Health and Care Plan as this has developed. All HWB providers and commissioners are committed and signed up to the Mindful Employer standard and LYPFT are ranked 34 out of the top 50 employers nationally for being an inclusive employer. Our emerging Local Care Partnerships are key to this new service delivery. This is based on the 13 neighbourhood teams. The Future in Mind Strategy has introduced 5 young MindMate champions to help spread the word online and with peer groups in schools and community youth centres.

February 2017

Public meeting

2. Reducing Health Inequalities through Innovation and System Change

Recommendations:

- Commissioners to review their procurement mechanisms after raising concerns that Leeds CCGs (and providers) did not procure Leeds made products.

Update:

The Inclusive Growth Strategy reflects this commitment and now includes a commitment to link procurement opportunities to job creation. This includes securing better outcomes for the Leeds economy in terms of jobs, skills and supply chains from procurement by the public and private sectors, and through major development and infrastructure projects

The Leeds Academic Health Partnership (LAHP) is developing its Health Innovation Leeds proposal to include a closer working relationship between collaborative trialling and local adoption of products (this includes working with local innovators and suppliers).

3. Reducing Health Inequalities through Innovation and System Change

Recommendations:

- To identify which organisations will lead and progress the roll-out of various innovation initiatives and to ensure that localities with historical health challenges are included.

Update:

In November 2017 the LAHP Board approved a Strategy identifying 6 collaborative work programmes which align closely with the Leeds Health and Wellbeing Strategy, Leeds Health and Care Plan and Inclusive Growth Strategy. Based on extensive consultation, the selection of the programmes was based on their potential to support reductions in inequality (e.g. deprivation/socio-economic impact; ethnicity) and positive impact on citizens and sustainability.

4. Introducing the Leeds Commitment to Carers

Recommendations:

- Endorse the Leeds Commitment to Carers
- That the Leeds Carers Partnership is tasked with promoting the Leeds Commitment to Carers and reviewing all action plans
- That HWB receive a progress report from the Leeds Carers Partnership in 2018

Update:

Completed action plans have been received from 10 organisations in Leeds. The Commitment to Carers was launched to Leeds Employers at the Carers Rights Day event, hosted by Carers Leeds, which generated great interest.

April 2017

Short public meeting

5. Draft NHS Leeds Clinical Commissioning Groups (CCGs) Annual Reports 2016-2017

Recommendations:

- That the CCGs provide timescales in relation to next year's report along with proposals for involving the Board in its development and agreement

Update:

As part of their annual reports, CCGs have a statutory requirement to include a review of how they have contributed to the delivery of any joint health and wellbeing strategy and to consult with the Health and Wellbeing Board in preparing it. The HWB will be engaged in February 2018 in the 2018 reporting cycle. The CCG Partnership is working to an initial deadline for a draft annual report to be prepared and submitted to NHS England by midday, 20 April 2018.

6. Leeds Health and Care Plan

Actions for Consideration:

- To provide a basic explanation about what the Leeds Plan is, what it aims to do, what the format is and how the components all fit together
- To articulate outcomes for people/the whole person - articulating what is going to change for the individual, their families, and communities, what services will look like and what they will offer, how resources (money and staff) will be used differently to make this happen, and what people can do for themselves (population behaviours) to support this
- To make sure this reads as a plan specifically for Leeds
- To simply describe how the Leeds Health and Care Plan fits with other strategies and plans e.g. LHWS, STP, Mental Health Framework, air quality strategy, etc

Update:

A basic explanation of the Leeds Plan has been developed in a narrative document, with a Leeds focus, which has been shared and agreed with HWB. This included format and details of change, with other resources e.g. video stories in production. How strategies link is part of an ongoing conversation and there is more to do to align these as plans develop.

7. iBCF (Spring Monies)

Actions for Consideration:

- Proposals for BCF investment to
 - o Be used wisely and to help system flow
 - o Join up with the Leeds Health and Care Plan ambitions
 - o Concentrate on and use the strength in our communities
 - o Deliver return on investment (ROI) rather than prop up services in the extreme short term
 - o Consider integrated hubs and estates benefits e.g. buying out costly spaces/building and bringing in neighbours and integrated teams to support service redesign and delivery
- Next steps
 - o Develop a financial plan
 - o Partners to provide any other ideas and proposals
 - o Go to BCF Delivery Group, BCF Partnership Board and ICE and then back to Health and Wellbeing Board

Update:

As 'Team Leeds' we submitted our iBCF 2017-19 improved Better Care Fund (iBCF) Plans to NHS England with approval received on 30th October 2017. Next steps have included reviewing the business cases for each of the schemes by a cross-partner panel to ensure they will address the challenges we face (health and wellbeing, care quality and finance and efficiency). Schemes are also assessed and refined around expenditure, benefits realisation, and impact on partners. Some of the approved bids are for schemes which directly support the Leeds Local Delivery Plan (our preparations for winter). Work is underway to streamline the reporting and governance for the schemes by merging the BCF Delivery Group and the Leeds Plan Delivery Group and aligning each of the schemes to a Leeds Plan programme.

8. Being the best city for health requires the best workforce

Recommendations:

- HWB to support discussions about the Living Wage and attend the Low Pay Seminar when arranged
- Oversee/raise the profile of the Supporting Disabled People into Employment Project to ensure it remains consistent with the city's health and wellbeing priorities and participate in a 'health, wellbeing and employment workshop' in October 2017
- Continue to note and support the development of Leeds Health and Care Academy and to receive regular updates on progress
- The City Workforce Workstream to be used to understand and plan responses to these challenges and keep the Board up to date with progress

Update:

A piece of work undertaken to understand levels of Living Wage being paid across the health and care organisations in the city was followed by a verbal agreement through the Partnership Executive Group to move to Leeds Living Wage as standard. The HWB held a workshop in October 2017 to consider the Supporting Disabled People into Employment Project (see item 25). The Leeds Health and Care Academy goes live on the 1st April 2018.

9. Leeds Health and Care Quarterly Financial Reporting

Recommendations:

- To further develop a shared system-wide response and assurance that the financial challenge will be met
- As part of the Boards' role to provide clear guidance to the Leeds Health and Care Partnership Executive Group on the possible actions required to achieve financial sustainability, the Board asked that PEG:
 - o Convene a workshop to consider and identify the opportunities for collaboration and budget sharing
 - o Undertake a piece of work to gather and understand savings and Return on Investment

Update:

A series of workshops have taken place in each of the areas across the West Yorkshire and Harrogate patch (facilitated by York Health Economics Consortium and KD Network Analytics) aiming to ensure that there is a consistent approach to understanding the financial position in each area. The Leeds workshop was attended by Directors of Finance and PEG members. Work is currently underway between the Directors of Finance and planning leads to share plans for 18/19 financial year to help ensure they line up.

10. Leeds Health and Care Plan: Progressing a conversation with citizens

Recommendations:

- To take an update back to Community Committees
- Add wording to Leeds Plan to recognise the interaction between Leeds £ and inclusive growth / business.
- To make the language more accessible (and one of the personas could be about someone with a personal budget)
- Clarify who will make the decisions
- Edit the description of Health and Wellbeing Board
- Include more Leeds based rather than national figures
- To explain the extended primary care model in more detail in the September meeting of the Health and Wellbeing Board

Update:

Community Committees have been updated and engaged on Leeds Plan. Wording that links Leeds £ to growth in the city is now part of an accessible narrative that has been drafted and circulated. Clarity of decision making and the HWB description has been updated and HWB profile raised in the document. Targets in the Plan and details of the financial challenge are based on Leeds figures. The HWB has had presentations on the Local Care Partnership model.

11. System Integration

Recommendations:

- Endorse the process to develop a blueprint for system integration in Leeds as a key element of the Leeds Health and Wellbeing Strategy
- Confirm how the Board would like to be engaged with this work going forward. It is proposed that a session occurs with Health and Wellbeing Board members to provide strategic steer as the work develops.

Update:

HWB requested that this item return to the Board to be shared and discussed in a public meeting. This item was presented to HWB on 28th September 2017 (see recommendations 18). The HWB supported the direction of travel in the emerging PHM Blueprint and asked for the item to be presented and signed off at the public meeting in September.

12. HWB membership

Recommendations:

- Invite Sam Millar to join Health and Wellbeing Board as Safer Communities representative.

Update:

As part of the HWB's commitment to tackling the wider determinants of health, Board members invited Superintendent Sam Millar to join the Board as a Safer Communities representative.

13. Reflections on HWB visits to A+E (Jan 2017) and agreeing future visits to other front line services

Actions for Consideration:

- Thea Stein stated that LCH will lead on the planning of a HWB session (approximately October) that will be part seminar and part citizen story. This will likely be in the form of citizen and staff presentations, such as District Nurses.
- Cath Roff highlighted the need for something that captures the balance of risk, how decisions impact on and a children and young people's focus too. Healthwatch and Leeds Older People's Forum could also be involved.

Update:

Work is being progressed, based on the suggestions of HWB Board members, to arrange a seminar to provide an insight into Neighbourhood Teams, what a typical day or evening shift looks like, and to hear from a service user about their experience of the service.

14. Leeds Local Delivery Plan

Actions for Consideration:

- Health and Wellbeing Board wants practical examples of what will be different and will it work:
 - o The Plan to be re-written or to have an accompanying narrative so that it can easily be explained or passed on to others
 - o A different and brave conversation is needed with the public that is linked with the Leeds Health and Wellbeing Strategy and the Leeds Health and Care Plan that the Health and Wellbeing Board can steer.
- To strengthen the involvement of the third sector in the process and invite a representative to the 1st August testing
- Primary Care needs to have a stronger reference
- Needs linking at a West Yorkshire level as we can't do this in isolation

Update:

An accompanying narrative was developed with various forums and groups and returned to the Board. A third sector representative attended the 1st August testing. There has also been third sector involvement at various testing points, including the formal monitoring of the plan at Systems Resilience Assurance Board (SRAB) which has third sector attendance. To progress action, the system is working with NHS England to develop a recovery plan, which will contain additional actions and process changes to strengthen our delivery and improve services for patients during the winter period. In addition, we have reviewed our system wide reporting and escalation processes and have already been testing these. Further refinement of escalation action is ongoing. Daily reporting has been implemented for sample GP practices and there is close working with GPs around GP streaming in A+E, out of hours and additional clinics. Leeds colleagues attend the West Yorkshire urgent care programme delivery board, and we liaise with other colleagues around 999, 111 and ambulance response services.

15. Leeds Autism Strategy

Actions for Consideration:

- That the Strategy be taken forward and that elements discussed are picked up with the relevant organisations and services.
- To take the opportunity to further improve flagging across systems (in particular primary care and secondary care) to allow staff to better respond to a person's needs.
- That autism needs factoring in to the mental health services that wrap around our 13 neighbourhood teams.
- That the funding situation regarding mental health services (a number are non-recurrent) is factored into our challenging conversations.
- Continue work to explore how IAPT and community mental health services can be better integrated. Thea Stein and Dawn Hanwell to check how autistic people with mental health issues are reflected within this, particular, around access to services.
- Children's autism waiting list and the scrutiny response could be considered at a future meeting of the Health and Wellbeing Board.

Update:

The Autism Partnership Board (APB) has developed an action plan and is prioritising the 4 areas of training, mental health, the criminal justice system and travel training. The APB continues to meet on a quarterly basis to work on the various strands of the agreed action plan. Improvements to the flagging need to be rolled out to other parts of the system. Both LCH (i.e. IAPT) and LYPFT are beginning a process of monitoring the numbers of autistic people using their services and providing awareness training for their staff. A training session day for elected members is organised for 29th Jan 2018.

16. Unhealthy Attitudes

Actions for Consideration:

- To have a one city approach to tackling these issues (with education, crime/safety and other partners), linked to our compassionate city ambitions.
- That the Board consider an action plan at a future meeting, developed through the LGBT+ Hub Sub Group on Health and Social Care, working with representatives from all the key organisations and partners.
- Possibility of developing a kitemark for LGBT appropriate services and providers, which would include appropriate bespoke training for care staff that is co-produced.
- To have a conversation with NHS England about waiting lists for specially commissioned gender identity services.
- Explore the use of new models of care under the Leeds Health and Care Plan to trial training in new teams on this issue, using posts that centre on better conversations to engage with this issue across the city.
- Explore opportunity for GP practices to strengthen the quality and consistency of peer training on this issue, building on training provided by LCH.

Update:

The Health and Wellbeing Board agreed that this item return to the September public meeting for formal commitment to the recommendations (see item 22 for details). Additional recommendations from the Board such as the development of a Kitemark will be developed together via the Working Group.

September 2017

Public meeting

17. Continuing a conversation with citizens: Leeds Health and Care Plan

Recommendations:

- Endorse and support the consultation plans.
- To consider the role of the public sector more widely to contribute to Leeds Plan ambitions and the changing conversations with staff and citizens.
- The future role of hospitals in community care.
- Involve young people, third sector and targeting people who were hard to reach or usually do.
- Design solutions from the bottom, up and include a focus on individual responsibility for keeping myself well.

Update:

Consultation plans have been endorsed and are progressing, including targeted and broader public engagement. Wider public sector is being engaged through developing staff conversations, but further engagement is required, e.g. with national public bodies that have staff in Leeds. The role of hospitals in community care is being made clearer through the frailty and musculoskeletal (MSK) programmes in the Leeds Plan. Young people have been consulted, but greater alignment is needed between the Children and Young People's Plan and Leeds Plan. The third sector is helping to reach seldom heard groups and community involvement is emphasised through funded 'better conversations' training for significant staff numbers.

18. System Integration – a Blueprint for Leeds

Recommendations:

- HWB to champion Population Health Management principles as a key delivery vehicle for the system to deliver the Leeds Health and Wellbeing Strategy and endorse the Blueprint for Population Health Management.
- To do further work to clarify if and how the Cluster partnerships ensure join up between responding to needs of children and needs of the parent. The HWB to receive a report on proposals.

Update:

As a result of the HWB discussion meetings have continued between children's commissioners and providers to progress and align work. The children and families commissioners are due to present at the Accountable Care Development Board in January with a focus on how the community approach could align with the emerging neighbourhood geography. Population Health Management will ultimately facilitate a joining-up of the adults approach with the children and families agenda in response to feedback that this is currently largely misaligned.

19. Leeds Health and Care Local System Delivery Plan 2017-18

Recommendations:

- Reinforce our shared ownership and collective action as 'Team Leeds' as we deliver Leeds Health and Care Local System Delivery Plan 2017-18.
- Agree that the approach taken to plan for winter aligns with our shared city ambitions.

Update:

The link to Leeds Health and Wellbeing Strategy has been strengthened in the narrative. The Clinical Senate has now been engaged several times and there has been regular discussion at the Partnership Executive Group and Board to Board. We await news on a funding bid (£2.55m) to support general system flow, mental health and primary care.

20. Integrated Better Care Fund (IBCF) Plan 2017-19 and Spring Monies

Recommendations:

- Noted and agreed the Plan.
- Board noted that Delayed Transfer of Care (DTOC) targets would be reviewed in November and the Board requested further information when available.

Update:

A paper was prepared in partnership for the HWB in November 2017, providing a summary of the term DTOC, how DTOCs are categorised, the current position in relation to number of DTOCs, and the degree of challenge associated with delivery of IBCF target. (see item 30).

21. Annual refresh of the Future in Mind: Leeds Local Transformation Plan for children and young people's mental health and wellbeing

Recommendations:

- To consider securing GP representation on the Clusters.
- Explore how the offer for children and young people in mental health crisis can be improved (reducing over reliance on out of hours and A+E).
- HWB members to:
 - o support, approve and champion the Future in Mind: Leeds strategy and underpinning Local Transformation Plan (LTP)
 - o recognise and share the achievements to date (detailed in the plan), progressed in the first years of the Future in Mind LTP funding allocations
 - o endorse how the child and young person's voice has been integral in developing the priority work-streams and going forward is embedded in the co-production of their delivery

Update:

The HWB has ratified the refresh of our Local Transformation Plan. Since then:

- *MindMate Champion programme - we now have 74% Primary schools, 78% Secondary schools, 100% SILCs, 93% Children Centres signed up*
- *5 young people with lived experience of mental health (age 16-24) recruited to be MindMate Ambassadors to represent the MindMate website at events, to do inroad work in schools and youth settings and to inform further development of website*
- *MindMate social media campaign underway raising the profile of MindMate and number of visits to the site*
- *Crisis operational group established and applying for national funding to support creation of a Safe Space for young people in the city*

We will also ensure connections between clusters and the new Local Care Partnerships as they develop.

22. Unhealthy Attitudes – A ‘one city’ approach for Leeds

Recommendations:

- Support the establishment of a Sub Group of the LGBT+ Hub focusing on Health and Social Care and nominate representatives from each partner organisation to attend this
- Task the LGBT+ Hub Sub Group on Health and Social Care with developing an action plan to deliver the recommendations of the Unhealthy Attitudes Report
- Task the Sub Group with identifying any additional actions that may need to be delivered to ensure Health and Social Care services are fully inclusive for LGBT+ people
- Task the Sub Group with consulting and engaging with the LGBT+ community as required to deliver the action plan
- HWB to receive regular update reports on progress in delivering the action plan

Update:

6 meetings are being set for 2018 with each focusing on one of the 5 main areas of the Stonewall action plan. Nominees have been put forward by most of the partnership organisations now and gaps are being filled. The working group will be a mix of senior leaders and operational staff and a review of progress meeting will take place at the year end, with a report on progress being drawn up to bring back to Health and Wellbeing Board.

October 2017

Workshop session

23. West Yorkshire and Harrogate Health and Care Partnership: Our next steps

Actions for Consideration:

- To ensure that the ‘Next Steps’ document reflects:
 - o the Leeds approach (e.g. bottom up, community focus, role of the third sector, etc)
 - o the importance of targeted pieces of work on small cohorts that have high levels of need and have a high cost to the system
 - o the voice of children, young people and families e.g. children and young people with long term conditions, the impact the behaviour/actions of adults have on children and young people
 - o young carers e.g. identifying and supporting a young carer for an adult with a long term condition
- To clarify collective action to tackle variation across the region, outlining impact on localities and how change will be measured and communicated
- To remove/define technical language
- To articulate the leadership and process required to identify pilots/examples of good practice across the localities and how they can be implemented regionally at pace

Update:

The revised ‘Next Steps’ reflects HWB discussion with more Plain English, ‘all age’, life-course approach, greater focus on tackling health inequalities/social determinants of health, and includes best practice (e.g. Leeds Neighbourhood Networks and Community Committee engagement). It states strong support for an NHS free at the point of delivery and commits to subsidiarity – meaning work is done locally unless it meets a clear test for regional working. A new Communities subgroup has been created, and the third sector and adult social care are now members of the System Leadership Executive Group. Senior officer engagement reflects the priorities in the Health and Wellbeing Strategy and partners have also pushed back where necessary against tight deadlines and top-down approaches. Local engagement supports the ‘left shift’ and the document now outlines a 3-4% increase in resources for primary care and community services over the life of the Next Steps strategy (2018-21).

24. Migrant health and wellbeing

Actions for Consideration:

- For Ian Cameron to lead the development of a migrant health and wellbeing working group, which would progress the issues raised through representation from the health and care partnership and report progress to the Leeds Health and Wellbeing Board and Strategic Migration Board
- To ensure clear communications with migrant communities, to continue engagement and understanding of who is impacted by changing changes and how they can be supported
- To ensure that plain English is used for public facing information
- Explore opportunity to reflect migrant health and wellbeing within the Leeds Health and Care Plan as part of the wider issues around health inequalities
- Clearly articulate how Leeds will support the most vulnerable as a system
- That data used in relation to migrants has to have clarity around the diversity, show issues impacting specific cohorts and where there are health inequalities
- To consider what more could be done to support migrants when commissioning for primary care in the future, strengthening the relationships between bespoke practices with experience of supporting migrants with wider practices

Update:

The membership of the new Migrant Health Board (MHB) is now being considered for its first meeting to progress issues around access, mental health, health protection, housing, abuse and data. A further significant issue concerns the 2017 amendments to the NHS (charges to Overseas Visitors) regulations. The MHB will develop an action plan, informed by front line services and communities, determining how Leeds will support the most vulnerable as a system. A work-stream to explore and improve relevant data collection will form part of the action plan. Good practice from the wide MHB partnerships will ensure processes, including the commissioning cycle, are responsive to the needs of the migrant community.

25. Improving health and work outcomes: Strategic direction and priorities for action

Actions for Consideration:

- To receive an update at a future meeting/workshop highlighting good practice and areas for progress across the member organisations
- For HWB organisations to improve health and work outcomes for their own workforce and support for those with long term conditions and disabilities
- To raise aspiration and ambition for those with disabilities to access employment, etc. as part of work occurring within the health and care sector (e.g. Leeds Health and Care Academy)
- Explore opportunities to reflect the work within the Leeds Health and Care Plan as part of the wider issues around health inequalities
- To explore further work around practices and organisations responding to people's individual workplace issues (e.g. work related stress pilot where practices acted as an advocate for a person on sick leave to engage with their employer)
- To champion and articulate the benefits to organisations for improving workplace health and wellbeing and sharing learning

Update:

A work programme is being developed to take forward recommendations from the Health and Wellbeing Board and as a response to the White Paper: Improving Lives. Initial action will focus on healthy workplaces, workforce development and integration of health and employment support.

November 2017

Public meeting

26. Inclusive Growth Strategy - Alignment with Health and Wellbeing Strategy

Recommendations:

- Closer alignment of the Health and Wellbeing and Inclusive Growth strategies
- Ensure broader health input from both commissioners and providers into the Inclusive Growth strategy via programmes such as Inclusive Anchors, Leeds Academic Health Partnership and the impending Innovation District and Nexus projects
- Inclusion of specific, place-based targets and priorities that partners could progress (such as reducing poverty, number of people with disabilities in employment)
- That the action plan reflects the needs of Leeds most vulnerable communities
- That Leeds Teaching Hospitals Trust commit to the Inclusive Anchors Programme
- To consider the 'Social Charter' and what action is already being taken by Leeds's Third Sector to support people back into work
- Link IGS and the Leeds Health & Care Plan, joining up with community cohesion and neighbourhood work
- To work with schools to ensure that a variety of roles in the jobs market are promoted to support aspiration and ensure that young people are given opportunities, can meet adults from a variety of skilled jobs
- Partners to use their influence as commissioners and employers to promote apprenticeship opportunities and mechanisms which assist people into and back to work
- Commissioners to influence and contribute as employers and buyers - making sure low paid staff are supported and paid a living wage; seeking high quality and supporting not for profit care for local communities through partnerships with social enterprise. Future commissioning to consider care delivery differently - to be inclusive and framed around local communities

Update:

Stronger links have been made across health and economic development. The health section of the Inclusive Growth strategy has been written by Health Partnerships. Leeds Teaching Hospital NHS Trust (LTHT) and Leeds City Council (LCC) have been working on the inclusive anchors programme. A business breakfast with 9 health businesses has taken place. The Innovation District has been informed by strong partnerships across University, LTHT and LCC. Living wage discussions have taken place at HWB and across the City. The Disability and Employment Project is in development to improve access to good work for people with disabilities including mental health. The Leeds Academic Health Partnership Strategy seeks to contribute significantly to inclusive Growth and will be presented to HWB in February 2018.

27. Making a breakthrough: a different approach to affect change - Supporting the Inactive to become Active

Recommendations:

- That 'physical activity' could be promoted as part of the Leeds Health and Care Plan, noting that any campaign would need to be sustainable with a long term commitment
- That schools, health visitors and parents encourage physical activity
- That the third sector has a key role to play in being able to provide information on what is provided throughout Leeds communities
- That NHS CCG commits to factoring in physical activity in its approach to commissioning pathways of care, particularly for musculoskeletal disorders; and the commitment to build this into health coaching and Making Every Contact Count policies
- To link physical activity to Mindful Employer measures

- Explore opportunities for a campaign of information and signposting on the location of cycle paths, walkways and bridleways alongside information on cycle safety.
- Explore extension of the Leeds Cycleway to link St James's and the Leeds General Infirmary

Update:

NHS commissioning will be picked up in the Leeds Health and Care Plan. LCC has a Health and Wellbeing group chaired by HR and physical activity is already embedded in Mindful Employer. Schools, health visitors and parents are encouraging physical activity through a range of initiatives, including a doubling of the PE and School Sport Premium, an early Years Physical Activity Toolkit, Leeds Urban Bike Park, and City Connect Cycle Superhighway. Conversations are underway to explore a Cycleway to link St James's and the Leeds General Infirmary.

28. Making a breakthrough: a different approach to affect change - Air Quality

Recommendations:

- Support an integrated independent living and affordable warmth service to ensure that vulnerable people receive physical improvements to their homes that will allow them to be warm and well at home.
- Champion affordable warmth across the health and social care sectors, to ensure that trusted frontline carers continue to refer clients for support.
- Consider joint investment in energy efficiency improvements in particularly vulnerable residents where there is a health business case (i.e. to improve hospital discharge processes).
- Participate in the air quality consultation process.
- Commitment to provide input in to the Leeds Transport Conversation
- Provide advice and guidance on how best to link through to the city's health professionals to promote key messages on air quality.
- Encourage the city's health organisations to lead by example in terms of their own fleet and travel planning.
- Consider how best to utilise air pollution data to support vulnerable groups
- Further information on this would be sent directly to Board members and partners to encourage consideration of electric vehicle use.
- Both Leeds Community Healthcare NHS Trust and Leeds and York Partnership NHS Foundation Trust representatives expressed an interest in closer working with Leeds Teaching Hospitals NHS Trust to see the work being done there in terms of the vehicle fleet and reducing individual air pollution.
- Department for the Environment, Food and Rural Affairs had recommended the use of Clean Air Zones (CAZ) in Leeds to tackle pollution, with 4 key roads requiring action. A further report would be presented to the Board for consultation once CAZ areas are determined.

Update:

LCC teams working together to procure the new Home Independence and Warmth Service. Leeds Community Health will promote the Warmth for Wellbeing/Warm Well Homes scheme. Energy efficiency and heating improvements are being provided to private sector residents suffering from cold related illness through these schemes and some will benefit from the Warm Homes Fund. The air quality consultation is now live until 2nd March 2018 and further communications will be developed to raise awareness of the impact of poor air quality. Grants are available to business/organisations/public sector to install EV charge points. LCC Fleet are working with LTHT on vehicle procurement and have trialled EV.

29. Making a breakthrough: a different approach to affect change - Domestic Violence (DV) and Abuse

Recommendations:

- To continue to identify opportunities to increase capacity at the Front Door Safeguarding Hub
- To identify new opportunities to upskill staff and services to identify and respond to Domestic Violence and in particular issues of coercion and control
- To remove barriers and improve access to appropriate services for people with complex needs who are experiencing domestic violence
- To consider ways to increase services and interventions available to perpetrators of domestic violence
- To encourage more primary care, GP practices and health and care settings to introduce a routine domestic violence enquiry as a general rule
- To consider the long term impact of what children or others have witnessed in a DV environment

Update:

As part of a West Yorkshire work programme, Leeds leads on a range of initiatives to improve responses to victims of domestic violence with complex needs with a particular focus on mental health, drugs and alcohol and immigration. Improvements to referral pathways are developing following a series of OBA events on migrant communities, health related issues and LGBT+ issues. Training includes opportunities to upskill a range of services to work with domestic violence perpetrators to increase capacity across the city. Caring Dads supports men who are abusive. Currently (Jan 18), 16 GP surgeries are undertaking routine enquiry with a further 24 expressing interest in doing so. Midwives and Health Visitors currently deliver routine enquiry and it is standard in Leeds services with DV Quality Mark. Conversations with Children and Families Service are exploring potential for considering the long term impact of what children or others have witnessed in a DV environment.

30. Brief overview of Delayed Transfers of Care (DTOC) and non-elective admissions

Recommendations:

- To submitted a letter to NHS England from the Health and Wellbeing Board challenging the current data baseline advocating a revised baseline for Leeds
- To note the challenges and risks faced by the Health and Care System partners in Leeds associated with delivery of the agreed iBCF trajectory
- To request future updates and reports back to HWB

Update:

City-wide partners have been working together to understand and develop their action plan around delays. One cause of delays across the system is people awaiting EMI (Elderly Mentally Inform) / Dementia beds so separate work has commenced to strengthen capacity out of hospital to support this group of people with complex needs.

31. Pharmacy Needs Assessment 2018-21

Recommendations:

- To note that the Pharmacy Needs Assessment is on track and progressing to consultation stage

Update:

The pharmaceutical needs assessment is underway and encourages HWB members to participate in the consultation phase. The PNA will return to HWB for discussion in February 2018.

January 2018

Workshop session

In January 2018, the Health and Wellbeing Board held a development session, giving HWB members the opportunity to consider progress to date, what is working well and what improvements can be made. Board members also considered their work plan for the next 12 months. This session was built on the details contained earlier within this report as well as the latest national review of HWBs 'The Power of Place'. Due to the strength of relationships and collaboration between Board members, the session did not require an external facilitator. A summary of discussion is provided below.

Where are we coming from?

HWB Members reflected on highlights from the last 12 months, noting progress has been made amidst ongoing challenges, such as improved mental health pathways, increased workforce training and support, and results of the Frailty Unit. However, the Board also recognised there is more to do and challenged themselves to stretch into areas where more improvements are needed.

The strength of the partnership was also acknowledged, reflecting that the Board now holds conversations as 'one system', works well when tested by winter pressures, and maintains high standards in engaging with staff and citizens.

Two elements were seen to underpin the culture and behaviour of the Board; firstly, that partners are all held together by the clear and credible Leeds Health and Wellbeing Strategy; secondly, by the strength of shared values across the partnership, rooted in a recognition of the assets and strengths of Leeds communities.

The HWB received an update on the indicators of the Leeds Health and Wellbeing Strategy (see p.38-39), which showed indicated positive overall improvements, with opportunities to move further faster. These discussions will feed into the Joint Strategic Needs Assessment process which is starting again soon.

Where are we now?

The HWB considered its place-based role, reflecting on how it does it work, with whom and the extent of its reach and impact. The Board acknowledged the successes it has had in driving health in all policy and ensuring strong links with other city-wide ambitions e.g. the Inclusive Growth Strategy.

There are numerous examples where the Board has shaped and influenced the direction of work, and ensured a Leeds focus in regional and national processes. However, there were suggestions of where relationships could be strengthened in order to further benefit, such as with the Local Economic Partnership.

Given the sound relationships between health and care leaders, the HWB also provides a space for collective thinking to create very different, local health and care solutions. This means Leeds has the opportunity to combine a focus on place and voice – ensuring that decisions are made with a Leeds focus based on what people and communities are saying.

Where are we going?

From 2018, the Health and Wellbeing Board will officially convene Board to Board sessions. These meetings bring together a larger number of health and care partners to discuss key strategic topics, share perspectives and agree collective actions. This approach is unique to Leeds and makes sure that everyone is joined up and working towards the same goals for the city and for our citizens.

Suggestions for the 2018/19 HWB work plan, included, specialist housing, commissioning and provide services differently, workforce challenges, mental health, and future planning to support people with dementia and learning disabilities.

Leeds Health and Wellbeing Strategy 2016-2021 - KPIs						January 2018
	Baseline 2015/16	Previous Full Year	Current	Trend	DOT	Comparison
Priority	A Child Friendly City and the best start in life					
Indicator 1	Infant mortality - Infant mortality rate (per 1,000 live births)					
	3.6 (2012-14)	4.1 (2013-15)	4.4 (2014-16)			Higher than England, not stat sig; 3rd lowest core city
Story behind the baseline	Lagged data. Last two years has seen an increase in rates following a number of years of declining rates. Rate is greater in deprived areas of Leeds as is the rate of increase. Three year average is not significantly different to England average.					
Data Source	Leeds Public Health Outcomes Framework					
Indicator 2	Educational attainment at 16 - Progress 8					
	New Measure	-0.06 2015-16 academic year	0.06 2016-17 academic year			2017 Progress 8 rank 40th out of 152 LAs; 2nd Quartile
Story behind the baseline	Against attainment measures (attainment 8, pass/strong pass in English and maths) Leeds performs in 3rd quartile of LAs. Leeds non-disadvantaged pupils at all key stages achieve similar to non disadvantaged nationally, however the gaps between disadvantaged pupils in Leeds and national non-disadvantaged are too wide and compare poorly.					
Data Source	DFE sourced. 2017 reformed GCSEs in English, English Literature and maths limits comparability with previous years					
Priority	Strong, engaged and well connected communities					
Indicator 3	Percentage of people working in Leeds earning under the Living Wage defined by the Living Wage Foundation					
Indicator 4	Increased self reporting of domestic violence and abuse incidents					
	25% (12 months to June 16)	27.4% (12 months to March 17)	26.6% (12 months to Nov 17)			N/A
Story behind the baseline	The volume of domestic incidents reported to Police in Leeds increased by 9.1% in the 12 months to November 2017; 19,837 incidents reported, with a repeat victim rate of 45.2%. There has been stability in the proportion of domestic incidents reported by the victim. The 12 month victim self-reporting rate was 26.6% (Nov-17), this is an indication of victim confidence to report domestic abuse.					
Data Source	LCC BCP - Safer Leeds					
Indicator 5	Incidents of hate crime					
	1726 (12 months to March 16)	2192 (12 months to March 17)	2305 (12 months to Nov 17)			N/A
Story behind the baseline	The volume of hate incidents reported to Police in Leeds increased by 10.1% in the 12 months to November 2017; 2,305 hate incidents were reported to Police. 72.7% of hate incidents were identified as Race hate motivated, (1,676 race hate incidents).					
Data Source	LCC BCP - Safer Leeds					
Indicator 6	Number of new referrals of carers to Carers Leeds					
Priority	Housing and the environment enables all people to be healthy					
Indicator 7	Number of houses in fuel poverty					
	13.5% (2015)	NA	NA	NA	NA	National 11% Core Cities 14.6% Y&H 12.4%
Story behind the baseline	The number of households in fuel poverty is calculated nationally based on average incomes compared to the average cost of heating homes. The figures published in 2017 were for 2015. Between 2014 and 2015, fuel poverty increased from 11.9% of households in Leeds, Yorkshire & the Humber increased from 11.8% to 12.4% and nationally 10.6% of households to 11% of households.					
Data Source	LCC BCP / Department for Business, Energy & Industrial Strategy Government Statistics					
Priority	A strong economy with quality jobs for local people					
Indicator 8	Number of young people who are not in employment, education or training (NEET)					
	NA	6.0% (Dec 16-Feb 17 average)	5.1% (August 17)	NA	NA	Dec- Feb Leeds 98th LA / in line with the national ave
Story behind the baseline	The headline performance measure combines NEET with the not known rate. From the 14,510 identified young people in years twelve and thirteen, 870 were NEET; 6%, made up of 2.9% NEET and 3.1% not known. The August figure of 5.1% represents the end of the academic year, the measure resets at the start of each academic year.					
Data Source	CYPP reporting to CFTB / DFE - new national measure from 2016/17 academic year					
Indicator 9	Jobs Growth in the Leeds economy (private sector)					
	363.0 thousand (2015)	366.4 thousand (2016 provisional)				Leeds 15-16 rate of change 2nd lowest of core cities
Story behind the baseline	The latest available result is 2016 provisional, this will be confirmed October 2018. The BRES result for 2016 is 366,400 employees and working proprietors in the private sector. This is an increase of 3,400 compared with 363,000 in 2015 a 0.9% increase; this is made up of 252,100 full time employees, 106,200 part time employees and 8,100 working proprietors. The growth of 3,400 comprises a decrease of 2,000 in full time employees, an increase of 5,200 in part time employees and an increase of 200 in working proprietors. Full time employees account for 69% of private sector employment.					
Data Source	LCC - BCP ONS - Business Register and Employment Survey (BRES): Full, part-time and proprietor private sector employment					
Priority	More people physically active more often					
Indicator 10	Percentage of physically active adults					
	NA - New Methodology		24.8% inactive (May 17)	NA	NA	England - 61% Active 14% Fairly 26% Inactive
Story behind the baseline	Based on the October 2017 publication for the period May 16 to May 17 62% of Leeds adults are considered active 13% fairly active and 25% inactive. Definitions are based on periods of moderate activity of 10 minutes or more in a week; active is considered above 150 minutes in total, inactive less than 30 minutes and fairly active in between. The next full year report is available in March 2018, when more reliable comparator figures will be available.					
Data Source	LCC-BCP Public Health Outcomes Framework - Sport England Adults Active Lives Survey					
Indicator 11	Excess weight in 10-11 year olds					
	34.23 2014	35.41 2016	33.49 2017			England 34.25 2017
Story behind the baseline	The national child measurement programme measures children in reception (age 5) and Year 6 (age 11) school years. 2017 shows a decline in year 6 after an increase in 2016. 33.5 % are considered with excess weight this includes 19.1% considered obese. There is a relationship with deprivation, in 2016 the Leeds deprived rate was 41.7%. 2014-2017 the percentage with excess weight in reception has declined from 23 to 21%, Leeds rates at reception and Y6 compare well.					
Data Source	DFE National Child Measurement Programme CYPP - CFTB report BCP-LCC Public Health Outcomes Framework					
Priority	A stronger focus on prevention					
Indicator 12	Potential years of life lost from causes considered avoidable					
	5449 per 100,000 2013-15	5515 per 100,000 2014-16	na	1.2% increase		Life Expectancy at birth lower than England 3rd highest core city
Story behind the baseline	Avoidable potential life years lost levelled off in 2013-2015 after 2 periods of reducing rates this has been followed by a slight increase in 2014-16. The increase is greater in deprived Leeds at 3.1% and consequently the gap between deprived Leeds (9363) and the rest of Leeds (4600) is widening, with deprived more than double that of the rest of Leeds. 2014-16 shows life expectancy in Leeds at 80.7 and in deprived Leeds at 76.6 %.					
Data Source	LCC BCP Leeds Public Health Outcomes Framework					
Indicator 13	Percentage of adults over 18 that smoke					
	21.2% Q4 14-15	20.1% Q4 16-17	19.8% Q1 17-18			2016 Smoking prevalence Leeds 17.8% higher than Eng 15.5% 3rd highest core city
Story behind the baseline	Adult smoking prevalence in the 18+ population is consistently reducing. While the rate of reduction is greater in deprived Leeds the rate in these communities at 31.6% 2017-18 Q1 remains well above the city. Leeds rate is also above national.					
Data Source	LCC BCP Leeds Public Health Outcomes Framework					

Leeds Health and Well-Being Strategy - KPIs						January 2018
	Baseline 2015/16	Previous Full Year	Current	Trend	DOT	Comparison
Priority	Support self-care with more people managing their own conditions					
Indicator 14	Proportion of people feeling supported to manage their condition					
	92.9% very or fairly confident Jul-Sept 15 & Jan-Mar 16	92.4% very or fairly confident Jan-Mar 17				England 92.1%
Story behind the baseline	The national GP survey indicates that 92% of people with long term conditions consider that they are very (44%) or fairly confident (49%) that they have enough support from local services or organisations to help manage their long-term health condition(s). Results are collated from returns for the three CCG areas; the results across the three CCGs are consistent with each other with only small, often single, percentage point differences.					
Data Source	GP Patient Survey					
Priority	Value mental and physical health equally					
Indicator 15	Percentage of young people reporting they are happy with the number of good friends they have.					
	83% happy or very happy 15-16 school year	82% happy or very happy 16-17 school year	NA			NA
Story behind the baseline	Over 80% of children and young people are happy or very happy with the number of good friends they have with a further 14% OK. 2016 results were marginally better but in 2017 returns at 10914 were 21% greater than 2016 and results have not been weighted to ensure consistent cohorts. Primary results are more positive than secondary with the main difference being a 13 point reduction in very happy and a 11 point increase in happy. 2% of secondary pupils are very unhappy.					
Data Source	Leeds My Health My School Survey					
Indicator 16	Premature under 75 mortality rate in adults with serious mental illness					
	452.1 2014/15					England 370.0 2014/15 Y&H 376.9
Story behind the baseline	The ratio (expressed as a percentage) of the observed number of deaths in adults in contact with secondary mental health services to the expected number of deaths in that population based on age-specific mortality rates in the general population of England. The cohort included on this measure grew from 17,473 in 2009/10 to over 30,000 in 2014/15 and the number of deaths from 234 to 446. Leeds rate was increased in 2014/15 and in the fourth quartile but NHS digital suggest measure is not comparable year on year.					
Data Source	NHS PH Profiles NHS Digital Indicator Portal					
Indicator 17	Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate (percentage point)					
	34.5 gap 2014-15 Q4 37% employed	30.6 gap 2016-17 Q4 47.8% employed	27.3 gap 2017-18 Q1 45.3% employed			Leeds gap is lower than national 31.3 Q1
Story behind the baseline	While subject to period on period variation, in part due to how the data is assembled, the overall direction is positive with Leeds gap narrowing and employment rates improving and comparing well with national. Cohort represents approximately 9% of workforce.					
Data Source	Health and Social Care Information Centre. NHS Digital Asked to note potential variabilities in sampling & uncertain impacts of changes in weightings for different					
Priority	The best care in the right place at the right time					
Indicator 18	DTC Bed days measure - 18+ Leeds Citizens. Average number of bed days delays per day by 100,000 pop					
	new measure	new measure	Nov 2017 18.1			October 2017 (19.6 beds per day) rank 139
Story behind the baseline	More of a live measure than some others. Better Care Fund Target is 8.5 bed days, average March to October was 15.9. Extensive work is ongoing and the reasons behind performance are understood and being addressed, efforts are structured around hospital provision LTHT, LYPFT and out of area. Patient choice followed by nursing home provision are currently the leading reasons for delay. Divides in November to 12.1 NHS, 4.9 Social Care 1.1 both.					
Data Source	Revised measure in line with national - NHS England					
Indicator 19	Number of bed weeks care in residential and nursing care homes for older people supported by the local authority (Over 65)					
	131,369 2015-16	129,846 2016-17	November estimate for year: 124,583			NA
Story behind the baseline	Numbers of bed weeks in homes supported by the LA is reducing, if the current estimate for this financial year holds the reduction will be just over 5% over two years in the context of potential demand pressures. Linked to a more strength based and preventative approach as articulated in Better Lives Strategy.					
Data Source	LCC Adult Social Care performance framework					
Indicator 20	Emergency admissions for acute conditions that should not usually require hospital admission (per 100,000)					
	1174.9 (2014-15)	1353.1 (2015-16)				England 15/16 1318.9 14/15 1277.1
Story behind the baseline	Data is heavily lagged with the last reported year showing an increase in cases requiring admission					
Data Source	NHS Outcomes Framework 3a Feb 2017					
Indicator 21	Emergency readmissions within 30 days of discharge from hospital					

*Some proxies have been substituted where another measure is now in more common usage or are being explored further.

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Leeds Health and Wellbeing Board



Report author: Simon Foy/Tony Cooke/Holly Dannhauser

Report of: Tony Cooke (Chief Officer, Health Partnerships) and Simon Foy (Head of Intelligence and Policy, Leeds City Council)

Report to: Leeds Health and Wellbeing Board

Date: 19th February 2018

Subject: Joint Strategic Assessment: more comprehensive approach to city-wide analysis

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

- The Health and Wellbeing Board has a statutory responsibility to produce a Joint Strategic Assessment (JSA) to inform the direction and effectiveness of the Health and Wellbeing Strategy. The JSA will assess how Leeds has progressed against the ambition set out in the Health and Wellbeing Strategy 2016-2021, reflect on the priorities outlined in the last JSNA and identify priorities for the future.
- We propose a forward-looking approach to the ownership, production and utilisation of the next JSA, considering the wider determinants of health and wellbeing and facilitating policy linkages across Best Council, NHS, Leeds Plan, West Yorkshire (NHS and Local Government), Best City and partner priorities, benchmarking Leeds' performance against our neighbours and other core cities. The analysis will combine quantitative and qualitative evidence to provide a rich intelligence at community and city-wide level. It will also outline inequalities and best practice in tackling these.
- This will give us an opportunity to understand to assess progress at the mid-point of the Health and Wellbeing Strategy and to use the analysis to set a clear future direction of travel that reflects our values as a City, prioritising our ambition to an inclusive and ambitious City that is the Best core City for Health and Wellbeing.

- We are keen to learn from good practice and innovation from elsewhere, e.g. the *Future Generations* approach in Cardiff and the *VitalsSigns* work in Berkshire.
- Strong ownership, input and commitment from all relevant partners is a key elements in ensuring JSAs have traction on the strategies they are aimed at influencing. It will be vital that the development of the JSA is grounded in elected member/clinical leader, third sector, partnership and community engagement.
- It will be vital that the JSA and the work that flows from it is accessible and widely communicated. A wide engagement around the data and analysis should help establish a single shared narrative across the partnership, supporting an open approach to continuing challenges and opportunities and to any adjustments to policy and practice.

Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the change from a Joint Strategic Needs Assessment to a Joint Strategic Assessment, reflecting the 'working with' approach and reflecting strengths and assets based approach developed in communities and neighbourhoods
- Endorse the extension of the JSA to cover the wider determinants of health in line with the refreshed Health and Wellbeing Strategy/Leeds Plan, Best Council/Best City priorities (paragraphs 3.1-3.3)
- Actively support and contribute to a strong partnership approach to the JSA (paragraphs 3.6-3.10)
- Agree the establishment of a partnership task and finish group to drive the JSA (paragraphs 3.11)

1 Purpose of this report

- 1.1 This paper sets out proposals for a broader, forward-looking approach to the ownership, production and utilisation of the Joint Strategic (Needs) Assessment, which will consider the wider determinants of health and wellbeing and facilitate policy linkages across Best Council and Best City Priorities.

2 Background information

- 2.1 The Health and Social Care Act 2012 introduced a statutory responsibility for Health and Wellbeing Boards to commission Joint Strategic Needs Assessments (JSAs) which in-turn would form the analytical basis to inform the direction and effectiveness of Health and Wellbeing Strategies.
- 2.2 There has been significant flexibility in how JSNAs are produced. Many areas, reflecting the focus on strengths and assets already produce Joint Strategic Assessments, or use an altogether different term. The Welsh Government, after the passing of the Future Generations Act, uses this act to tie together a broad approach to health, wellbeing, environment and economy informed by a series of needs assessments.

3 Main issues

Context

- 3.1 The last JSA was undertaken in 2015, it was a development of earlier JSNAs, which focussed primarily on the core drivers of health and wellbeing. The JSNA 2015 sought to widen the analysis to incorporate the impact of deprivation and inequality, demographic change and patterns of housing quality and provision. It is proposed to build on this approach to further extend the JSA to cover the wider determinants of health, including:
- Inclusive Growth;
 - Education and Skills;
 - Safe and Strong communities (with a focus on localities, particularly our most disadvantaged communities);
 - Housing;
 - Environment, transport and green space
- 3.2 A wider, future-looking analysis also reflects the direction of travel in terms of the Best Council/Best City priorities. The refreshed 2018/19 Best Council Plan seeks to strengthen policy linkages across priorities and puts health and wellbeing, alongside inclusive growth, at the heart of our approach.
- 3.3 Given its statutory responsibility for the JSA, the Leeds Health and Wellbeing Board has been engaged about the next iteration of the process in a workshop session in January 2018. The HWB recommended that the JSA:
- Make best use of the city's excellent informatics and data capabilities to ensure the product of the JSA drive conversation and action.
 - Use existing data sets, for example Mental Health Needs Assessment.

- Take the opportunity to link with data sets developed for the Local Care Partnerships.
- Link quantitative and qualitative information, ensuring that the voices of our most vulnerable communities are heard.
- Make use of the city's asset-based philosophy and transition to a Joint Strategic Assessment.

Learning from others: Future Generations Wales

- 3.4 There is much we can learn and adopt as best practice from other parts of the UK; the Future Generations approach in Wales is just one example. The Well-being of Future Generations Act 2015 requires public bodies in Wales to think about the long-term impact of their decisions, to extend planning horizons and think longer term about the kind of region/City we might want to develop, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
- 3.5 Future Generations is a partnership based approach that sets a clear direction of travel rooted in a values based approach to planning across the life-course. It aligns an approach that develops opportunities for young people with understanding how best we can support older people to remain independent in communities for longer. It links planning, transport, environment with health, care and promotes creative and innovative responses to technology, economic development and education.

Our approach

- 3.6 The Health and Wellbeing Board champions the Leeds approach to 'working with', which has become central to the way we plan and deliver health and care in the city and the way that we engage and interact with our regional and national colleagues. This will be reflected in the JSA, ensuring it takes a partnership approach from the outset, looks at assets and needs and blends quantitative data with qualitative voice and experience of our communities.
- 3.7 We will analyse the key themes from the needs assessments that have been completed since the 2012 Leeds JSNA. This includes ones on 0-19 Years; Healthy Living; Men's health; Maternity; Pharmacy Needs; Suicide; Mental Health; NHS Health Check and home independence. We also want to embed the use of local profiles that have been developed for example at ward level, and at neighbourhood team level for frontline staff to use to drive service improvement and development
- 3.8 We propose that the JSA will reflect the central importance of place-based leadership and benchmarking Leeds' performance against our neighbours and other core cities. We are also keen to learn from good practice and innovation from elsewhere, for example the Future Generations and the VitalsSigns work in Berkshire which is a neighbourhood focused approach that identifies key priorities for each Berkshire neighbourhood and challenges inequalities from within a community focused approach to needs and assets.

- 3.9 Lessons from the production of previous JSNAs suggest that strong ownership, input and commitment from relevant partners a key elements in ensuring JSAs have traction on the strategies they are aimed at influencing. Therefore it is proposed that a task and finish group will be established from across the council and wider partnership to lead the production of the JSA.
- 3.10 Finally it will be vital that the JSA and the work that flows from it is accessible and widely communicated. The Leeds Observatory should provide the platform for dissemination and interaction, coupled with an effective approach to communicating with the public in plain English.

Next Steps

- 3.11 The first step is to establish the JSA task and finish group and set out the timescales for the production of the JSA. Detailed work will be required to scope-out the precise coverage and structure of the JSA, together with an initial audit of analysis that will contribute to the JSA. This will include developing steps of engagement and clarifying how qualitative/voice data from communities will be included.
- 3.12 We propose to return to the Health and Wellbeing Board in July with these initial stages completed. The overall aim will be to produce the JSA in autumn. There will be an ongoing process of JSA development – it will be an iterative, online document/process.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 This iteration of the JSA is just beginning. Given the statutory responsibility, the Health and Wellbeing Board (HWB) have been engaged at a workshop session in January 2018. This public meeting is the next stage of what will be regular and ongoing engagement with the HWB.
- 4.1.2 The JSA will combine quantitative and qualitative evidence, meaning that engagement and hearing citizen voice is integral to the process. The HWB will be kept cited with steps taken and future plans to engage with communities.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 By its very nature, the JSA process helps to identify inequalities and illustrate trends. This in turn can inform the design and delivery of our Leeds Health and Wellbeing Strategy, with the vision of improving the health of the poorest the fastest.
- 4.2.2 Regularly engaging the HWB throughout the process ensures that the Board's work plan can respond accordingly.

4.3 Resources and value for money

- 4.3.1 Building local intelligence strengthens our evidence base, making for better public policy and informing commissioning decisions.

4.4 Legal Implications, access to information and call In

4.4.1 There are no access to information and call-in implications arising from this report.

4.5 Risk management

4.5.1 Any implications will be escalated to the Board as required.

5 Conclusions

5.1 We propose a forward-looking approach to the ownership, production and utilisation of the next JSA, considering the wider determinants of health and wellbeing and facilitating policy linkages across Best Council, Best City and partner priorities, benchmarking Leeds' performance against our neighbours and other core cities.

5.2 This will give us an opportunity to understand to assess progress at the mid-point of the Health and Wellbeing Strategy and to use the analysis to set a clear future direction of travel that reflects our values as a City, prioritising our ambition to an inclusive and ambitious City that is the Best core City for Health and Wellbeing.

5.3 We are keen to learn from good practice and innovation from elsewhere, e.g. the Future Generations approach in Cardiff and the VitalsSigns work in Berkshire.

5.4 Strong ownership, input and commitment from all relevant partners is a key elements in ensuring JSAs have traction on the strategies they are aimed at influencing. It will be vital that the JSA and the work that flows from it is accessible and widely communicated.

5.5 The JSA will combine quantitative and qualitative evidence, meaning that engagement and hearing citizen voice is integral to the process. The HWB will be kept cited with steps taken and future plans to engage with communities.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the change from a Joint Strategic Needs Assessment to a Joint Strategic Assessment, reflecting the 'working with' approach and reflecting strengths and assets based approach developed in communities and neighbourhoods
- Endorse the extension of the JSA to cover the wider determinants of health in line with the refreshed Health and Wellbeing Strategy/Leeds Plan, Best Council/Best City priorities (paragraphs 3.1-3.3)
- Actively support and contribute to a strong partnership approach to the JSA (paragraphs 3.6-3.10)
- Agree the establishment of a partnership task and finish group to drive the JSA (paragraphs 3.11)

7 Background documents

7.1 None.

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How does this help reduce health inequalities in Leeds?

By its very nature, the JSA process helps to identify inequalities and illustrate trends. This in turn can inform the design and delivery of our Leeds Health and Wellbeing Strategy, with the vision of improving the health of the poorest the fastest.

Regularly engaging the HWB throughout the process ensures that the Board's work plan can respond accordingly.

How does this help create a high quality health and care system?

The findings of the JSA process can be used to design and deliver more effective services, community led solutions, and to make improvements to the way the health and care system works together for people in Leeds. It is a fundamental evidence base for the Leeds Health and Wellbeing Strategy, which, in its current iteration, is well established and guides the work of the health and care system.

How does this help to have a financially sustainable health and care system?

The JSA process allows us to understand the needs in the city as well as the assets that exist to meet the needs. This is an exercise in intelligence gathering – knowing more about our communities enables better decision making and more effective solutions.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds Health and Wellbeing Board



Report author: Colin Mawhinney
(Head of Health Innovation, Health Partnerships Team)

Report of: Chief Officer Health Partnerships Team

Report to: Leeds Health and Wellbeing Board

Date: 19 February 2018

Subject: Leeds Academic Health Partnerships Strategic Framework

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No
If relevant, access to information procedure rule number:		
Appendix number:		

Summary of main issues

1. In February 2018 Leeds and Health and Wellbeing Board considered a report and a series of presentations on Reducing Health Inequalities through Innovation and System Change. The Report included a description of an emerging programme of active projects led by the Leeds Academic Health Partnership (LAHP) to deliver better health outcomes reduced health inequality and more jobs together with the stimulation of investment in health and social care. The Board indicated that it wished to receive future progress reports as and when appropriate.
2. The Leeds Academic Health Partnership has since February 2017 made good progress to develop a clear strategic framework of priorities to guide the selection of projects to be selected in its programme of work. These closely align with the Council's Vision for Leeds to be the best city in the UK, and one that is compassionate with a strong economy, which tackles poverty and reduces the inequalities that still exist. The Strategic Framework also specifically aligns to priorities identified in the Leeds Health and Wellbeing Strategy, the Leeds Health and Care Plan, Leeds Inclusive Growth Strategy.
3. A key aim of the Strategic Framework is to support the delivery of each partners' own (and shared) strategies and priorities and help to simplify, not add to, complexity. It has therefore been produced in a power point format attached rather than in a traditional report format. This will make it easier for partners for reference purposes and help them assimilate commitments into their longer term planning and support for education,

innovation and research in Health and Care. It's launched in the context of ongoing progress to deliver projects with the potential to bring significant benefits to our local health and care system. This report includes a brief summary of the main areas of progress.

Recommendations

The Health and Wellbeing Board is asked to:

1. Note the Strategic Framework priorities and progress made by the Leeds Academic Health Partnership and its programme to deliver better health outcomes, reduced health inequality and more jobs and stimulate investment in health and social care within the City's Health and Wellbeing Strategy.
2. Note that the Chief Officer, Health Partnerships Team will be responsible for overseeing implementation by the LAHP of its programme.

1 Purpose of this report

- 1.1 This report provides an update on the progress made by the Leeds Academic Health Partnership to establish a Strategic Framework of priorities and summary of its programme of active projects to deliver these. It acknowledges the role of the Leeds Academic Health Partnership in a wider strategic context of the Council's Corporate Plan priorities to create a strong economy and compassionate city and to align with the Leeds Health and Well Being Strategy, Leeds Health and Care Plan and Leeds Inclusive Growth Strategy

2 Background information

- 2.1 The Leeds Academic Health Partnership was launched in November 2015. Its purpose is to engage the educational and research capabilities of our universities with the health and care system and thus accelerate the adoption of research and new approaches to improve service outcomes, reduce inequalities and create investment and jobs. The LAHP Board consists of: Leeds City Council; the Leeds Teaching Hospital NHS Trust; Leeds and York Partnership NHS Foundation Trust; Leeds Community Healthcare; the city's three Clinical Commissioning Groups; and three universities (University of Leeds, Leeds Trinity and Leeds Beckett). It made provision for associate membership for The Yorkshire and Humber Academic Health Science Network and subsequently for Leeds City College and St Gemma's as affiliate members. It is currently chaired by Sir Alan Langlands, Vice-Chancellor of the University of Leeds and supported by a small team including time from Council Officers.
- 2.2 In February 2017 Leeds Health and Wellbeing Board received a report and presentation on the emerging programme of active projects led by the Leeds Academic Health Partnership (LAHP) to deliver better health outcomes reduced health inequality and more jobs together with the stimulation of investment in health and social care. These included initiatives to establish an Academy for Health and Social Care, opportunities to improve evaluation of innovation and the establishment of the new Centre for Personalised Medicine and Health. The Board requested that further reports detailing the LAHP's progress be submitted to future meetings. The Board indicated that it wished to receive future progress reports as and when appropriate

3 Main issues

- 3.1 **Strategic Priorities for the LAHP:** The second year of the LAHP's programme has focussed on developing a clear strategic framework of priorities to guide the selection of projects to be selected in its programme of work. The framework has been developed in the context of partnership working and its aims reflect a partnership ethos including;
- The Supporting of the delivery of partners' own (and shared) strategies and plans –helping to simplify, not add to, complexity of working across boundaries.

- Reflecting the breadth of the partnership, for example: physical and mental health; care provided in and out of hospital; health and social care; discovery science to applied health research
- Building the reputation of and adding value to all partner organisations and the city across the totality of the work programmes.
- Building on and bringing together existing strengths across the city and also develop areas of new capability

3.2 The Strategic Framework has therefore been produced in a power point format (attached) rather than in a traditional report format. This will make it easier for partners for reference purposes and help them assimilate commitments into their longer term planning and support for strengthen education, innovation and research in Health and Care. It's launched in the context of ongoing progress to deliver projects with the potential to bring significant benefits to our local health and care system.

3.3 The key priorities identified in the Strategic Document have been developed through consultation with each of the LAHP Board Members who in turn have sought to reflect their engagement in wider network of boards including the Leeds Health and Well Being Board and the Leeds Health and Care Plan Development Group. The priorities and enablers are therefore clearly aligned with the Leeds Health and Well Being Strategy and Leeds Health and Care Plan in addition to the Inclusive Growth Strategy and Leeds Skills and Talent Plan and are summarised in the table below

A Good Start in Life	
(1)	Obesity
(2)	Mental health
Living Well	
(3)	The cardio-metabolic human
(4)	Co-morbid physical and mental health
Health Ageing	
(5)	Frailty
(6)	End of life

3.4 In selecting the six core programmes the LAHP Board took into account both opportunity and stated needs of the wider Health and Care System. in this respect;

- All six can be seen through a lens of prevention and/or self-care;
- There is already a successful research base in most of the six areas, but room to develop and grow through collaboration and interdisciplinarity both across and within the universities
- All six have the potential to impact positively on citizens and the sustainability of the health and care system

- All six are nationally and internationally relevant as well as being important for Leeds, offering significant education and research opportunities
- All six have the potential to support reductions in inequality (e.g. deprivation/socio-economic impact; ethnicity)
- Clinical senate discussions about winter pressures/managing demand have focussed heavily on behaviour change and frailty/end of life care. The LAHP will have a key role in continuing to develop and deepen these relationships and to attract other innovators and investors into the City. =

3.5 **Supporting Infrastructure; The Enablers.** The LAHP will focus effort on supporting the success of these programmes and will do so by ensuring that a supporting infrastructure is in place to ensure their delivery. The aim is to be bid-ready and to proactively influence funding decisions in these areas. This infrastructure comprises 4 enablers as indicated in the table below;

One Workforce	Leeds Health and Social Care Academy
Information and Technology	A Learning Healthcare System
Personalisation	Leeds Centre for Personalised Medicine
A Culture of Health and Care Innovation	Health Innovate Leeds

3.6 **Summary of progress on the Enablers:** Good Progress has been made to establish and deliver each of these enabling projects as indicated below.

3.7 **One Workforce;** The Leeds Health and Social Care Academy. The city has a clear strategy to build “one workforce for Leeds”, where people employed in health and care can move freely across the boundaries of organisations so that the public and patients experience seamless health and care services, sometimes, referred to as “integrated care”. The LAHP has initiated this project to develop a seamless and sustainable workforce, organised around the public and patients enabled and supported by the (proposed) development of a Leeds Health and Social Care Academy.

3.8 The Leeds Health and Care Academy (the ‘Academy’) project transition team was established on the 1 October 2017, and is hosted by Leeds Teaching Hospitals NHS Trust. A project board is being established. A wider project stakeholder group is also being formed to ensure engagement and alignment with the wider health and care system, the membership of which is currently being confirmed. The planning and implementation stage is expected to take up to twelve months. The initial ‘go live’ date for the Academy is April 2018. A second phase of activity will be launched in September 2018, when significant learning and development activities will be delivered through the Academy.

3.9 **Information and Technology; A Learning Health care System;** The LAHP is helping to co-ordinate plans for a bid by Partners in the City to respond to a call for Expressions of Interest expected (in early March) from NHS England and Office of Life Sciences for Local Integrated Care Exemplars (LICRE) and Digital

Innovation Hubs (DIH). The call (with an expected value of up to £7m for each LICRE) seeks to significantly improve the digital infrastructure required to establish a local learning health and care systems based on the capturing of data for research to drive service improvement. Exemplars will be required to demonstrate how information can be shared between professionals and citizens at the point of care and to enable patients to be active participants in their own records.

- 3.10 **Personalisation;** The Leeds Centre for Personalised Medicine and Health (LCMPH): Personalised Medicine and Health is the process by which the decisions made about health and care by patients and the public, supported by clinicians, are enriched and improved by the availability of the best possible information, technology and evidence. The centre builds on the University of Leeds strengths in Precision Medicine and includes expertise in relation to cancer, muscular skeletal conditions, and medical devices and digital health.
- 3.11 Funding for the first phase (early health economic modelling) of the Prolaris project has been secured. The work will assess the cost-effectiveness of the Prolaris prostate cancer stratification test within the healthcare system, and will be led by Leeds Teaching Hospitals NHS Trust.
- 3.12 The LCPMH and SomaLogic have agreed to establish a pilot project within Leeds to develop and evaluate their SomaScan Health Insight technology. The proposed first project of the test-bed will focus around the prevention of Type II diabetes in at risk populations. An initial pilot will recruit around 100 patients in the second half of 2018, as preparation for a larger pilot to determine the population health impact in the greater Leeds patient population
- 3.13 **A Culture of Health and Care Innovation. Health Innovation Leeds:** The Report to Executive Board in July referred to plans to draw inward investment into Leeds and generate wealth for the city. The LAHP is developing a new service to promote Leeds as a centre for innovation, attract and then navigate innovators to a number of areas where we know the city has excellent strengths and capabilities and to work with the local health and care system to create a receptive culture and processes supporting innovation.
- 3.14 The Health Innovation Quarter service will build on wider investment in the proposed Innovation Quarter and help develop the capabilities outlined in the Science and Innovation Audit for Medical Technologies completed for the Department of Business, Energy and Industrial Strategy (BEIS), to highlight investment opportunities for the sector.
- 3.15 The Audit led by the University of Leeds was published at the end of September, to much acclaim, and maps the key assets hosted in Leeds City Region. It also notes that £350 m has been invested in developing the sector and in securing the position of Leeds as its leading centre in the UK and recommends that a further £250 m should be invested to enable it to exploit opportunities in the global health market. This has been influential in helping to shaping the subsequent announcement of a life Sciences Sector Deal.

- 3.16 This is intended to give the life sciences sector and government an agreed set of strategic goals that will ensure the UK builds on its exceptional reputation for science and research, genomics and clinical trials. Leeds features in several places in the published document which includes references to the Innovation Quarter, Nexus, a £40m Innovation Centre driven by the University of Leeds, which will actively incubate and grow start-ups, and the Leeds Health and Social Care Academy providing joined-up training and development for the 57,000 people who work in the health and care sector across the City of Leeds. The benefits for Leeds, like the other centres identified in the UK, will be breakthrough treatments, innovative medical research and technologies, and creation of high skilled jobs and investment

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 This report includes priorities based on meetings and decisions approved with all member partners represented on the LAHP Board including the City Council, local NHS organisations and all three Universities. The report therefore reflects the consultation arrangements incorporated in the advice and input provided by partners represented on the Board. For example the Leeds Health and Wellbeing Strategies and Inclusive Growth Strategies have included extensive local consultation during their development. The alignment of the strategic framework with both of these strategies takes into account the results of these consultations

4.2 Equality and diversity / cohesion and integration

- 4.2.1 The Strategic Framework seeks to prioritise projects to deliver the stated key outcomes of quality and efficiency, economic growth and inequalities as previously approved by the Council's Executive Board. The slides include a statement that the six core collaborative work programmes were selected on the basis that 'All six have the potential to support reductions in inequality (e.g. deprivation/socio-economic impact; ethnicity'. The framework is closely aligned the Leeds Health and Wellbeing Strategy with its commitment, 'where people who are the poorest improve their health the fastest'

4.3 Resources and value for money

- 4.3.1 The LAHP has total annual running costs of £683,000 covering staffing and seed funding for its programme of projects. This resource will be used to lever other flows of inward investment into the city health and care system as indicated in paragraphs 3.9 and 3.16.

4.4 Legal Implications, access to information and call In

- 4.4.1 This proposal is based on establishing a partnership which will be initially based on an informal partnership structure and without significant legal implications at this stage

4.5 Risk management

- 4.5.1 This report provides an update as requested previously by the Health and Well Being Board and does require a decision. There are therefore no specific risks arising from this report. An active partnership seeking to promote investment in leading edge innovation in individual projects will require its own system of risk management. These are incorporated in the project management arrangements deployed by the LAHP

5 Conclusions

- 5.1 The Leeds Academic Health Partnership continues to make good progress to develop its strategic framework and supporting programme to deliver better health outcomes; reduced health inequality and inclusive growth. Moreover this progress is feeding through to create national profile for the city and influence key policy and investment planning by the government as exemplified by the recently published Industrial Strategy Life Sciences Sector Deal.

6 Recommendations

The Health and Wellbeing Board is asked to:

1. Note the Strategic Framework priorities and progress made by the Leeds Academic Health Partnership and its programme to deliver better health outcomes, reduced health inequality and more jobs and stimulate investment in health and social care within the City's Health and Wellbeing Strategy.
2. Note that the Chief Officer, Health Partnerships Team will be responsible for overseeing implementation by the LAHP of its programme.

7 Background documents

- 7.1 February 2018 Leeds and Health and Wellbeing Board Report: Reducing Health Inequalities through Innovation and System Change

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Implementing the Leeds Health and Wellbeing Strategy 2016-21

How does this help reduce health inequalities in Leeds?

The LAHP and its strategic framework will make data analysis, technology and research expertise from our Universities available for better targeting and prioritisation of resources to ensure the Leeds Health and Wellbeing Strategic aim of supporting people who are the poorest improve their health the fastest. For example, The LAHP has been developing projects for better screening of lung cancer with Yorkshire Cancer Research and also Prostate Cancer with Myriad. Both conditions disproportionately affect the poorest sections of our society

How does this help create a high quality health and care system?

The LAHP is working to bring additional investment into health (through more successful Bids) quicker application of innovation to improve quality and cost effectiveness through accelerated trials and evaluation in the six core collaborative programmes and 4 enabling infrastructure projects. This will be holistic and encompasses physical and mental health; care provided in and out of hospital; health and social care

How does this help to have a financially sustainable health and care system?

Quicker evaluation and better profile will support the City's aim to win and attract more bids and investment. Its projects may also support the reduction of costs

Future challenges or opportunities

These are summarised in the slides attached. The Health and Care System is complex and has many current pressures which could distract from longer term opportunities and opportunities associated with a changing population and technology. It is essential that the LAHP Board remains closely aligned with the Health and Wellbeing Board in ensuring the optimum balance between short and longer term needs of the Health and Care system are addressed.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21

A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	

Strategy: 2017 to 2021

Board Meeting: 9 November 2017

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Innovation through collaboration



LEEDS



Leeds Academic Health
PARTNERSHIP

STRONG ECONOMY IN A COMPASSIONATE CITY

Page 78



3rd largest city in the UK¹

home to
3 million
people in Leeds City Region



Generating a
£64.6bn
economic output³

Part of
15 million
people in the Northern
Powerhouse

fastest growing city

Leeds is the
in the UK



we speak
170 languages

Best big city in
England
for standard of life²



Largest city
region
economy
outside of London⁵

A LEARNING CITY

3
universities



Totalling over
62,000
students



Including the 2017
University of the Year

LEADING IN INNOVATION



Home to
160

Med-tech &
health informatics
companies



Largest
concentration
of health
informaticians
in the UK⁵

Leeds
Care
Record

Connects the data from
half a million patient
records



Leeds has
22% of all digital
health jobs
in England⁴



SIMPLE AND STRONG HEALTH AND CARE SECTOR

£1.8bn
annual Leeds
spend on
health and care



57,000

people employed
across health & care

3 NHS Trusts
including one of the
largest teaching
hospitals in Europe³



Leeds City Council: 2016
Local Authority
of the Year

Single
commissioning voice





LAHP Members

Partners



Leeds Trinity
University



LEEDS
BECKETT
UNIVERSITY



UNIVERSITY OF LEEDS



The Leeds
Teaching Hospitals
NHS Trust



Leeds and York Partnership
NHS Foundation Trust



Leeds Community
Healthcare
NHS Trust



Leeds
CITY COUNCIL



Leeds Clinical Commissioning
Groups Partnership

Associates



YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK

Affiliates



Leeds City College



St. Gemma's
Hospice
Always caring



yorkshire cancer
research



LAHP Purpose

"To improve the health and well-being of the people of Leeds by engaging academic capabilities in education and research with the health and social care system across the city in order to speed up the adoption of research and innovation; creating inward investment, and raising the national and international profile and reputation of the city and LAHP member organisations."

Or, put simply:

**Innovation through
Collaboration**





Strategy Aims



Support the delivery of the partners' own (and shared) strategies and plans – help to simplify, not add to, complexity.



Build the reputation of and add value to all partner organisations and the city across the totality of the work programmes.



Reflect the breadth of the partnership, for example: physical *and* mental health; care provided in *and* out of hospital; health *and* social care; discovery science to applied health research



Build on and bring together existing strengths across the city and also develop areas of new capability



Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:
‘Leeds will be the best city for health and wellbeing’

And a clear vision:
‘Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest’



5 Outcomes:

1. People will live longer and have healthier lives
2. People will live, full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities



Context for Higher Education

Challenges

- **Competition:** for students and research funding
- **Research:** longer, interdisciplinary awards and establishment of recognised centres of excellence
- **Education:** uncertainty re home student funding settlement
- **Policy impacts and uncertainty:** e.g. fee changes impacting healthcare student numbers; Brexit impacting EU funding and revenue
- **Demographic changes**
- **Quality:** Increasingly discerning customers
- **Talent:** Attracting and retaining the best
- **Regulation:** OfS, UKRI, TEF, REF

Strategies

- Focus on excellence in education
 - Balanced portfolio of education programmes
- Balanced ratio of home vs. international students
 - Access and widening participation
 - New forms of provision e.g apprenticeships and digitally enabled learning
 - Interdisciplinarity
- Focus on research excellence
 - Build reputation through partnership with other national and international universities
- Grow partnerships with public sector and industry to deliver impactful research
 - Interdisciplinarity

Education

Research



LAHP Strategy: 2017 to 2021

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PREVENTION AND SELF-CARE

"Staying healthy for longer"

A Good Start in Life

Living Well

Healthy Ageing

- One Workforce ▪ Information and Technology ▪ Personalisation ▪
- A Culture of Health and Care Innovation ▪

- Quality and Efficiency ▪ Inequalities ▪ Inclusive Growth ▪

OUR GRAND CHALLENGE

PREVENTION AND SELF-CARE

"Staying healthier for longer"

A Good Start in Life

Living Well

Healthy Ageing

- One Workforce ▪ Information and Technology ▪ Personalisation ▪
- A Culture of Health and Care Innovation ▪

- Quality and Efficiency ▪ Inequalities ▪ Inclusive Growth ▪



Our Grand Challenge: Prevention and Self-Care

- “Wicked”, internationally-relevant problem
 - Requires sustained collaboration by several partners over a long period of time
 - Requires systematic, evidence-based effort and thorough evaluation
- ✓ Essential to health and care system sustainability
 - ✓ Relevant to NHS Five Year Forward View, Leeds Health and Well-Being Strategy, Leeds Health and Care Plan etc.
 - ✓ Provides education and research opportunities across all three universities
 - ✓ Relevant to the LAHP’s affiliate members
 - ✓ Encompasses physical and mental health; care provided in and out of hospital; health and social care
 - ✓ Ranges from discovery science to applied health research
 - ✓ Attractive to industry partners, as presents opportunity for long-term relationships
 - ✓ Possibilities for national and international profile building,
 - ✓ Supports ambition to the “best city for health and well-being” and the plans for the Innovation District.

CORE COLLABORATIVE WORK PROGRAMMES

PREVENTION AND SELF-CARE

"Staying healthier for longer"

A Good Start in Life

Living Well

Healthy Ageing

- One Workforce ▪ Information and Technology ▪ Personalisation ▪
- A Culture of Health and Care Innovation ▪

- Quality and Efficiency ▪ Inequalities ▪ Inclusive Growth ▪



Core Collaborative Work Programmes

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A Good Start in Life

- (1) Obesity
- (2) Mental health

Living Well

- (3) The cardio-metabolic human
- (4) Co-morbid physical and mental health

Healthy Ageing

- (5) Frailty
- (6) End of life

6 Active collaborative work programmes

4 Infrastructure projects will support the six core programmes

- ✓ Each member organisation will benefit from one or more of the programmes
 - ✓ Mix of mental and physical health
 - ✓ Care provided in and out of hospital
 - ✓ Health and social care
 - ✓ Mix of discovery science and applied health research
 - ✓ Mix of building on and bringing together existing excellence and growing new capability
-
- LAHP will focus effort on supporting their success, but will let other flowers bloom – though must support grand challenge and fulfil criteria
 - Aim to be bid-ready and to proactively influence funding decisions in these areas



Why these six?

- There were other contenders, but these six seem to have energy and momentum
- All six can be seen through a lens of prevention and/or self care
- There is already a successful research base in most of the six areas, but room to develop and grow through collaboration and interdisciplinarity both across and within the universities
- All six have the potential to impact positively on citizens and the sustainability of the health and care system
- All six are nationally and internationally relevant as well as being important for Leeds, offering significant education and research opportunities
- All six have the potential to support reductions in inequality (e.g. deprivation/socio-economic impact; ethnicity)
- Clinical senate discussions about winter pressures/managing demand have focussed heavily on behaviour change and frailty/end of life care

Some may not gain sufficient traction and/or the context might change, and it will be important to monitor regularly and shift focus and resources to other areas if necessary



Opportunities and Challenges

Page 90

- Build on areas of research strengths by connecting pieces together -- interdisciplinarity
- Trends in research funding – e.g. UK Prevention Research Partnership (£50m)
- The potential of the Leeds Care Record (which allows us to look at the whole patient pathway) put together with the analytical capabilities of the universities
- Capacity – for everyone – suggests we need a phased implementation plan
- Converting the knowledge we generate into practice

SUPPORTING INFRASTRUCTURE

PREVENTION AND SELF-CARE

"Staying healthier for longer"

A Good Start in Life

Living Well

Healthy Ageing

- One Workforce ▪ Information and Technology ▪ Personalisation ▪
- A Culture of Health and Care Innovation ▪

- Quality and Efficiency ▪ Inequalities ▪ Inclusive Growth ▪

Supporting Infrastructure

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- All six core work programmes will have implications for workforce and for information and technology.
- All six will provide opportunities for targeting treatment better through the stratification of citizens and patients and the personalisation of health and care interventions.
- To be successful, all six will need a culture to be in place which welcomes and embraces evidence and innovation in health and care practice.

One Workforce	Leeds Health and Social Care Academy
Information and Technology	A Learning Healthcare System
Personalisation	Leeds Centre for Personalised Medicine
A Culture of Health and Care Innovation	Health Innovate Leeds



Supporting Infrastructure: Leeds Health and Social Care Academy

VISION



A truly integrated, place-based workforce, with resources under one city management; creating efficiencies to reinvest in training, development and education



Unlocking opportunities through a joined up approach to social mobility, apprenticeships, and careers outreach



Radical upgrade the development offer to in-service workforce in partnership with universities and City College



Opportunity to market programmes nationally and internationally



Opportunity to support the acceleration of research and innovation into practice

Progress to Date

- LTHT identified a host organisation
- Transition Director and some team members now appointed
- Joint bid from UoL and LBU to NIHR to create a Workforce Policy Unit to enhance the national and international standing of the Academy
- Secured Health Education England funding to support the transition team
- NHS England have asked to join and collaborate on apprenticeships across the city, and there is interest from other national health arms length bodies based in Leeds. Ambition for 2000+ apprenticeships
- Go live date April 2018



Supporting Infrastructure: Leeds Centre for Personalised Medicine and Health

VISION



To be a global centre of excellence in personalised medicine and health - transforming the health, wealth and wellbeing of our citizens and the efficiency of our health and care services through world class research, innovation and enterprise



“To move away from a ‘one size fits all’ approach to the treatment and care of [citizens and] patients with a particular condition, to one which uses new approaches to better manage patients’ health and target therapies to achieve the best outcomes in the management of a patient’s disease or predisposition to disease.”

NHS England definition of personalised medicine

Progress to Date

- UoL identified as host organisation. LCPMH established; Head of Centre and small team appointed. System-wide board in place, chaired by Prof Paul Stewart. Board includes AHSN and NHS England
- Active projects in cancer, atrial fibrillation, diabetes and CVD with significant industry players such as Myriad, Roche and Somalogic
- Patient activation measures project in development to stratify level of patient engagement in own health and care
- Personalised mental health approaches being discussed with LYPFT
- CanTest – new and improved cancer diagnostics in general practice. SBRI bid submitted
- Living in Leeds proposal in development



Supporting Infrastructure: Learning Healthcare System

VISION



Learning from every citizen who uses our services and every patient we treat



Unlocking the potential of the Leeds Care Record



Exploiting the research expertise in the universities, and in particular the Leeds Institute for Data Analytics, to develop predictive algorithms and decision support tools



Bringing together existing city wide assets to be truly internationally leading

Progress to Date

- There is already a strong place-based approach to I&T
- Plans to create an Office of Data Analytics for the city
- Open standards approach in place
- Leeds Care Record still one of the few whole system electronic patient records in the world.
- Plans to give patients access and add to their own records
- Outcomes based commissioning
- LIDA established and growing in reputation and capability



Supporting Infrastructure: Health Innovate Leeds

VISION



Leeds will be *the* city in which to innovate in health and care. We will be the best navigation system in the UK for health and care innovators of all sizes



We will clearly articulate our needs and priorities to innovators so that it is easier for us to work together



We will work locally, nationally and internationally to accelerate the development of the best healthcare innovations



We will simplify access to the health and care system, working proactively to break down barriers to innovation at a local level

Progress to Date

- Developed the HIL structure and operating model with a Task and Finish Group
- Held business breakfast to engage with health and care innovators
- Worked with Healthwatch to develop citizen/people narrative
- Presented model to Integrated Commissioning Executive for feedback
- Working with AHSN and LEP to secure longer term funding options
- Engaging digital organisations to develop virtual presence



Supporting Infrastructure: A Culture of Health and Care Innovation

All programmes will develop **leading-edge, research-based, world-class solutions**

Leeds needs to continue to build a culture which welcomes and embraces evidence and innovation in health and care practice. **This is critical to our ambitions to be the best city for health and well-being.**

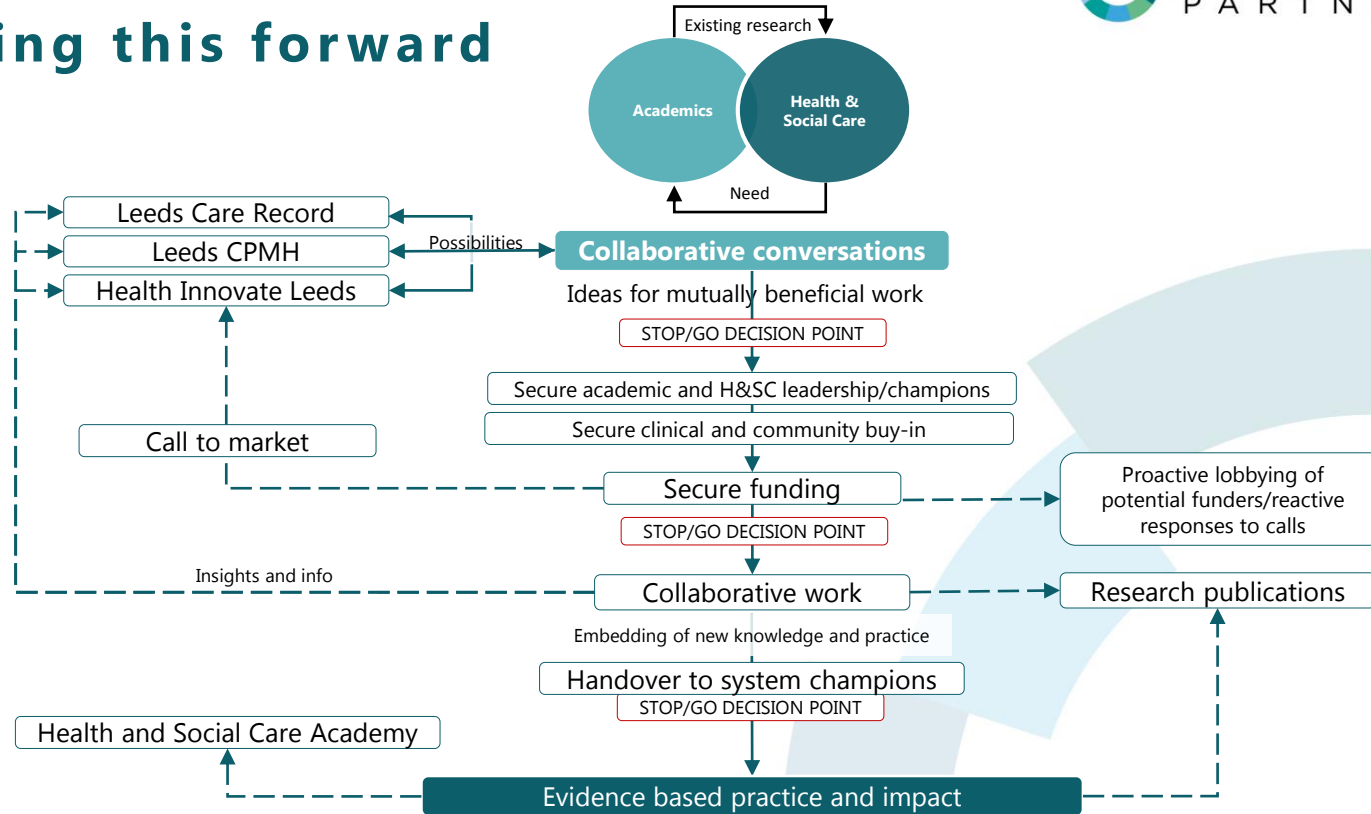
To support the further development of this culture, we will facilitate:

- Joined up leadership and “cheerleading” for innovation in health and care across the city
- Co-ordinated staff engagement through the Academy
- Capability building for partnership working through the Academy
- Marketing and communications campaigns, aimed at raising the profile of Leeds as a city of innovation in health and care
- The development of relationships across the workforces of our organisations and we will encourage networks to form naturally, serving mutual interests
- The establishment of good governance where it is needed



Taking this forward

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IMPACT

PREVENTION AND SELF-CARE

"Staying healthier for longer"

A Good Start in Life

Living Well

Healthy Ageing

- One Workforce ▪ Information and Technology ▪ Personalisation ▪
- A Culture of Health and Care Innovation ▪

- Quality and Efficiency ▪ Inequalities ▪ Inclusive Growth ▪



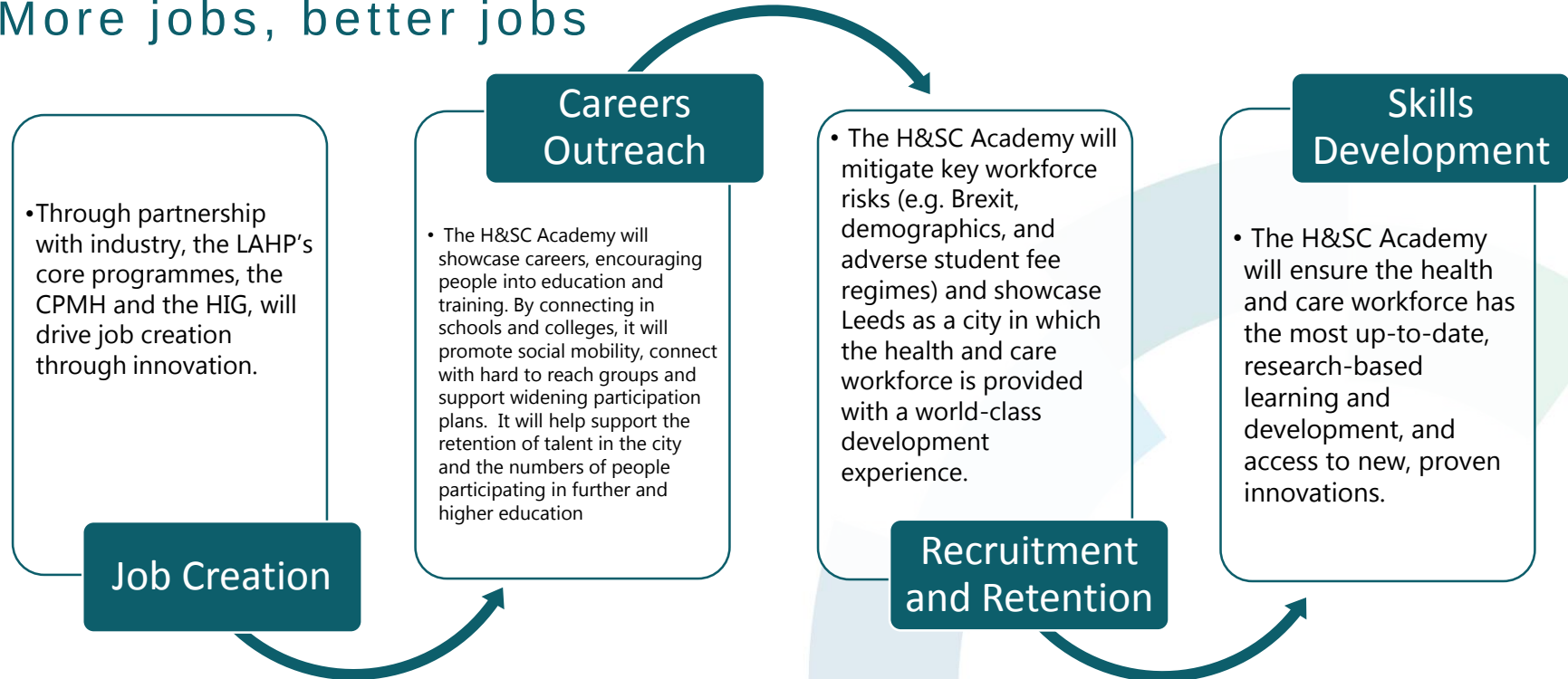
Impact: Outcomes of the LAHP Strategy





Impact: More jobs, better jobs

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LAHP Strategy: 2017 to 2021

PREVENTION AND SELF-CARE

"Staying healthier for longer"

A Good Start in Life	Living Well	Healthy Ageing
Obesity Mental health	Cardio-metabolic human Co-morbid physical/mental health	Frailty End of life
One Workforce Information and Technology Personalisation A Culture of Health and Care Innovation		Health and Social Care Academy
		Learning Healthcare System
		Leeds Centre for Personalised Medicine
		Health Innovate Leeds
▪ Quality and Efficiency ▪ ▪ Inequalities ▪ Inclusive Growth ▪		

Leeds Health and Wellbeing Board



Report author: Liz Bailey (Head of Public Health, Health in All Policies)

Report of: Ian Cameron (Director of Public Health, Leeds City Council)

Report to: Leeds Health and Wellbeing Board

Date: 19th February 2018

Subject: Pharmacy Needs Assessment 2018-21

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

Legislation changes

The Health and Social Care Act 2012 transferred responsibility for the developing and updating of Pharmaceutical Needs Assessment (PNAs) to Health and Wellbeing Boards (HWBs), becoming effective from 1st April 2013.

A Pharmaceutical Needs Assessment (PNA) is a statement of the need for pharmaceutical services. Pharmaceutical services are provided by Pharmacies Dispensing Appliance Contractors, Distance selling pharmacies, Dispensing Doctors and Local Pharmaceutical Services.

Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need, as set out in the relevant PNA.

Therefore, the primary purposes of the PNA are:

- To enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

- To identify any gaps, or potential gaps in community pharmacy coverage that may reduce access to pharmaceutical services for members of the public.

Pharmacy Needs Assessment process

The current PNA, which was approved by the Leeds Health and Wellbeing Board on 25th March 2015, expires on 31st March 2018 and an updated version to cover the next 3 years has been produced (attached as an appendix).

There has been a thorough process, consisting of desktop research, data collection via public and community pharmacy surveys, initial stakeholder consultation, data analysis and a further 60 day wider stakeholder consultation.

The 60 day consultation during which the draft PNA was on the Leeds Observatory site, invited comments from:

- All Elected Members
- All Leeds community pharmacists
- Neighbouring Health and Wellbeing Boards of Bradford District, Craven, Calderdale, Kirklees, Harrogate and Wakefield
- Third Sector representative of Leeds Health and Wellbeing Board
- Representatives of Leeds Clinical Commissioning Groups Partnership
- Leeds Local Medical Committee (LMC)
- Leeds Community Healthcare
- Leeds Teaching Hospital Trust
- Community Pharmacy West Yorkshire
- Local Professional Network (LPN) for Pharmacy
- Community Pharmacy North Yorkshire
- Community Pharmacy Humber
- Healthwatch Leeds
- Leeds prescribing GPs

A further Black and Minority Ethnic group (BAME) focus group, which also included individuals with other protected characteristics, was convened during this time to check whether this group's experience agreed with the findings of the draft PNA report. Amendments were made to the draft PNA report as a result of comments received during the 60 day consultation and the revised document is now presented as the final copy.

Once approved by the Health and Wellbeing Board, the completed PNA will be published and placed on the Leeds Observatory <http://observatory.leeds.gov.uk/> to replace the 2015-2018 version by the 1st April 2018.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the thorough processes undertaken to compile the PNA 2018-2021
- Note the findings and recommendations contained in the PNA 2018-2021
- Note that there are no current gaps in the provision of necessary services to meet the needs of the Leeds Health and Wellbeing Board area population– this includes

services inside the Leeds Health and Wellbeing Board (HWB) geographical area and services that sit outside the Leeds HWB area, yet service its population.

- Note that there are no current gaps in the provision of other relevant services to meet the needs of the population in the area of the Health and Wellbeing Board.
- Note that as of 1st January 2018, all areas of Leeds have a reasonable and adequate choice of pharmacies and pharmaceutical services in all areas of Leeds
- Note that the PNA has not identified any future needs which could not be met by pharmacies already on the pharmaceutical list, which would form part of related commissioning intentions.
- Note the follow up actions that have been taken, or will be taken
- Approve the PNA document ready for publication and placing on the Leeds Observatory website <http://observatory.leeds.gov.uk/> by 1st April 2018

1. Purpose of this report

- 1.1 To inform the Health and Wellbeing Board that the new Pharmacy Needs Assessment 2018-2021 has now been produced after a thorough and robust process, including a number of consultation measures as described below.
- 1.2 To provide the Health and Wellbeing Board with a summary of the findings of the PNA.
- 1.3 To inform the Health and Wellbeing Board that Leeds has a good spread of pharmaceutical services, very good access to pharmaceutical services and no current gaps in the provision of necessary services to meet the needs of the Leeds Health and Wellbeing Board area population
- 1.4 To inform the Health and Wellbeing Board that there are no current gaps in the provision of other relevant services to meet the needs of the Leeds Health and Wellbeing Board area population
- 1.5 To inform the Health and Wellbeing Board that the PNA has not identified any future needs which cannot be met by pharmacies already on the pharmaceutical list, which would, within the next three years form part of related commissioning intentions.
- 1.6 To inform the Health and Wellbeing Board that the PNA, having regard to likely changes to the number of people requiring pharmaceutical services, the demography of the area and the risks to the health and wellbeing of people in the area, has not identified any needs, which are not already being met, or cannot be met by existing providers.
- 1.7 To inform the Health and Wellbeing Board that it is only required to consider a revised assessment if there is a significant change to the need for pharmaceutical services

2. Background information

- 2.1 Health and Wellbeing Boards are required to publish and keep up to date their local Pharmacy Needs Assessment. The current one, which took effect from 01 April 2015 expires on 31st March 2018 and a new one must be published.
- 2.2 The Leeds Health and Wellbeing Strategy aims to put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. The Leeds Health and Well Being Board is responsible for overseeing the achievement of this vision and as a key part of the local health infrastructure, community pharmacists are ideally placed to contribute.
- 2.3 A Pharmacy Needs Assessment project group has been working together since April 2017 to plan the PNA work and ensure collection and analysis of information which has now been used to produce the Pharmacy Needs Assessment 2018-2021.
- 2.4 There has been a thorough process, consisting of the following process:
 - Desktop research
 - Formation and meeting of a PNA project group which drove the PNA process
 - Data collection- Community pharmacy survey distributed to all community pharmacies on NHS England's Leeds provider list
 - Data collection- Public survey to all individuals listed on the Leeds City Council's Citizens Panel
 - Data and information gathering from commissioners of community pharmacist services
 - Stakeholder consultation on current services, gaps and future needs analysis
 - Data analysis
 - Compilation of draft report
 - Wider consultation on draft report and consideration/incorporation of comments and amendments. This took place during the statutory period of 60 days from 4th December 2017 to 2nd February 2018.
 - Focus group on 10th January 2018 to receive and incorporate further feedback from Black and Minority Ethnic (BAME) groups and other individuals with protected characteristics.

Public Survey

- 2.5 A questionnaire was developed and distributed electronically to 3,350 online residents and in paper format to 600 residents through the Leeds City Council's Citizens' Panel.
- 2.6 Additional measures were taken to try to capture the views of young people via Youth Clubs and the LCC Young People's Voice and Influence Team. Further engagement mechanisms were used in an effort to reach minority ethnic groups and other hard to reach groups through Healthwatch the LCC Communities Team and Leeds Gypsy Traveller Exchange (GATE). Tweets were also shared through various council twitter accounts including – @LeedsCC_News @HWBBBoardLeeds

@BetterLivesLds @OneYouLeeds and a range of others were tagged, to stimulate involvement.

- 2.7 In the live survey period between 22nd August and 29th September 2017, 1059 online and 365 paper responses were received. Although not all returns were via Citizen Panel, the majority were and an approximate response rate of 36% was achieved.

Views of Community Pharmacists

- 2.8 A total of 178 community pharmacies, who were on the NHS England Pharmaceutical list were sent a paper questionnaire and 154 responses (94 paper and 60 online responses) were received back during the survey period, which ran from 25th August 2017 to 22nd September 2017. This corresponds to an 87% response rate. A further two pharmacies were later identified as a result of cross checking of information, but as this was outside the survey period when the hyperlink was no longer available, self-reported information from these pharmacies is not included in the survey findings.

Stakeholder Views

- 2.9 Stakeholder views were sought from a number of local agencies and statutory organisations as shown below:
- Community Pharmacy West Yorkshire
 - Leeds CCG Partnership
 - Healthwatch Leeds
 - Leeds Local Medical Committee
 - Leeds Teaching Hospital Trust
 - Adult Social Care LCC
 - Children's Services LCC
 - The Third sector representatives on the HWB
 - Carers Leeds
 - Leeds Involving People
 - Tenfold
 - MESMAC
 - Local Professional Network (LPN) for Pharmacy
- 2.10 Stakeholders were asked to rate the availability, quality and accessibility of community pharmacies in Leeds and responses were received from Community Pharmacy West Yorkshire, Healthwatch, NHS Leeds Clinical Commissioning Groups Partnership, Leeds Involving People and LCC Adult Social Care. A further individual response was received on this format from Age UK because the person found it more accessible than the community questionnaire.
- 2.11 The Local Medical Committee (LMC) returned a paper response to the Leeds City Council address as requested, but unfortunately this failed to arrive so could not be used. However, an LMC representative stated that the LMC agreed with the response sent in by Community Pharmacy West Yorkshire, so this was used.

- 2.12 The stakeholders were asked to rate the availability, quality and accessibility of community pharmacies and on the whole this was rated as very good or good; there was one quality and accessibility rating as 'okay'.
- 2.13 Most stakeholders were not aware of any gaps in the service now and felt it unlikely that there would be any gaps in the next three years.

Wider consultation

- 2.14 The draft PNA was then open for further consultation with and took comments from community pharmacists, other stakeholders and Elected Members during the statutory period of 60 days, which ran from 4th December 2017 to 2nd February 2018. Comments were received from Community Pharmacy West Yorkshire, Leeds Community Healthcare NHS Trust, NHS England and two community pharmacies. These comments were considered by the PNA project group and incorporated into the final document.
- 2.15 A Black and Minority Ethnic (BAME) focus group was also facilitated during this time to receive and incorporate further feedback from hard to reach individuals. This had a balance of male and female contributors and a small number of people with other protected characteristics i.e. disabilities were also present. These groups had not been well represented in the community survey, despite additional measures being taken to engage them.

3. Main issues

- 3.1 As of 1st January 2018, the 181 pharmacies which were working within the national contract in Leeds in 2015 has reduced by one to 180. These provide a wide range of essential and advanced pharmaceutical services to meet the needs of the Leeds population with no gaps in provision detected.
- 3.2 There are now seven distance-selling pharmacists, an increase of five since the last PNA.
- 3.3 Although distance selling pharmacies cannot provide face to face essential services, they can provide other services face to face. The Leeds community can receive pharmaceutical services from these, as well as any other distance selling pharmacists outside Leeds. Therefore Leeds continues to have good coverage of pharmaceutical services.
- 3.4 Geographical service provision of community pharmacies is generally very good and 73% of Leeds residents responding to the PNA survey reported they can reach a pharmacy in up to 10 minutes.
- 3.5 27 pharmacies are contracted by NHS England to open for a minimum 100 hours per week. Of the 154 pharmacies which replied to the PNA survey, 22 (14%) confirmed their 100 hour status.

- 3.6 At the time of the PNA survey, of the 154 pharmacies that returned a survey questionnaire, 52 (34%) had achieved HLP Level 1 and 84 (55%) were working towards HLP status. By January 2018, 149 had reached HLP Level 1.
- 3.7 HLPs help reduce health inequalities by adhering to quality criteria around workforce development, engaging with the local community and adhering to principles of a health promoting environment, including staff attitudes and actions and confidentiality for service users.
- 3.8 The Leeds Outer areas have fewer community pharmacies within a one mile buffer zone of their population and fewer open for extended hours, but the Outer North area has seven dispensing GP practices and there are seven distance selling pharmacies across Leeds which are available to the whole of the Leeds population. This means that there is reasonable and adequate choice of pharmacies and pharmaceutical services in all areas of Leeds and no gaps in geographical provision.

Opening Hours

- 3.9 22 pharmacies are open before 8am and 23 after 10pm. A total of 126 pharmacies are open on Saturday with 111 of these also open in the afternoon; 15 are open on Saturday mornings only. 41 pharmacies are open on a Sunday.
- 3.10 Parts of the Outer areas are less well covered, and in Outer North East, no pharmacy is open after 8 pm or before 8 am, so citizens may on occasion need to travel to the nearest pharmacy in a neighbouring Community Committee area.
- 3.11 27 pharmacies are contracted by NHS England to open for a minimum of 100 hours per week, an increase from 21 in 2015. 91% of pharmacies responding to the survey replied that extended opening hours of GPs had had no impact on the services they provide.

Citizen satisfaction with service accessibility, availability and provision

- 3.12 Satisfaction with access to pharmaceutical services is high with 80% of the residents in the PNA public survey self-reporting that availability of pharmacies in their area was very good (42%) or good (38%).
- 3.13 Satisfaction with the quality of pharmacies is also high. Just over three-quarters (76%) of residents responding to the PNA survey said that the quality of pharmacies in their area was very good, or good and the vast majority (95%) of residents self-reported that they have a choice as to which pharmacy they can use.
- 3.14 95% of residents reported that they are happy with the services that their local or usual pharmacy provides
- 3.15 Mapping of service provision illustrates that the vast majority of the PNA survey respondents live within one mile of a pharmacy and 73% of Leeds residents who replied to the citizen's survey can reach a community pharmacy in up to ten minutes.

- 3.16 87% of residents have access to public transport which takes them to within walking distance of a pharmacy and 71% of pharmacies report a bus or other public transport stop less than two minutes (walking at a moderate pace) from the pharmacy.
- 3.17 The dispensing service is used most by citizens with 35% regularly and 39% sometimes using this service. Buying over the counter medicines is also well used with 16% of respondents regularly and 63% sometimes doing so.
- 3.18 The electronic prescriptions service is highly valued with 40% of people regularly and 10% sometimes using this service.
- 3.19 Only 5% of people regularly use pharmacies to dispose of old or unwanted medicines but 44% sometimes do so.
- 3.20 Similarly, lifestyle services are infrequently used by citizens with only 1.4% going to their pharmacists for this purpose.
- 3.21 3.1% regularly, or sometime use their pharmacy for advice around Chronic Obstructive Pulmonary Disease (COPD), less than 1% of the respondents used chlamydia screening regularly, or sometimes and 0.8% regularly and 1.8% sometimes use the emergency contraception service.

Vulnerable Groups

- 3.22 143 (93%) of the 154 pharmacies responding to the survey reported they are part of the Leeds Dementia Friendly Scheme.
- 3.23 122 (79%) pharmacies have unaided disabled access and 146 (95%) have floors that are accessible by wheelchair. 120 (78%) pharmacies have blue badge parking within 10 metres of the pharmacy and a smaller number have facilities and adaptations to help people with physical, visual or hearing impairments, as well as older and less mobile people, access their service.
- 3.24 The PNA found evidence that pharmacies are well respected and well used by some marginalised groups e.g. Gypsy Travellers. However, it is possible that some of our newly emerging communities may experience some limitations of access in terms of language and cultural barriers.
- 3.25 22% of pharmacies reported they have all their staff trained and 19% have some staff trained around Equality and Diversity. 58% of responding pharmacies reported having no staff with equality and diversity training. Continuing to develop, exercise and extend where appropriate their expertise around Equality and Diversity will ensure that pharmacy teams can continue to respond fully to meeting the needs of a changing and increasingly diverse population.

- 3.26 Support and action by other professionals and locality staff to promote the role of community pharmacy for self-help advice amongst newly emerging communities may also be helpful.
- 3.27 Community pharmacies are a valuable and trusted public health resource and the potential of their role as described in the Community Pharmacy Forward View (2016) will, over the next three years continue to develop, adapt and grow alongside the changing health landscape. Capacity continues to build as demonstrated by the increase to 149 HLPs within the Leeds Health and Wellbeing Board area within a very short period of time.
- 3.28 New Models of Care will further change the local health landscape, including reassessing the role and potential of the community pharmacy team. There is capacity for this enhanced role to be done through the existing contracts, to enable them to contribute more fully towards supporting the health of local people.

4. Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 There have been several opportunities for consultation, engagement and hearing citizen voice during the course of the work. The project group, which steered the project consisted of representatives from LCC Public Health, NHS England, Community Pharmacy West Yorkshire, Healthwatch Leeds and the NHS Leeds Clinical Commissioning Groups Partnership (Patient Safety and Medicines Optimisation Team).
- 4.1.2 An electronic and paper questionnaire was developed and distributed through the Leeds City Council's Citizens' Panel. 3,350 residents were invited to respond online while 600 residents were sent a paper questionnaire. Additional measures were taken to capture the views of young people – via youth clubs and LCC Young People's Voice, Influence and Change Team – and those of BME groups – through Healthwatch, the LCC Communities Team and Leeds Gypsy Traveller Exchange (GATE). Tweets were also shared through various council twitter accounts, including @LeedsCC_News @HWBBBoardLeeds @BetterLivesLds @OneYouLeeds. A range of others were tagged to stimulate involvement.
- 4.1.3 This questionnaire invited citizens to provide their views and experience of using community pharmacies. This included access, availability (including out of hours), services used and general satisfaction with the pharmacies they used.
- 4.1.4 In the live survey period between 22nd August and 29th September 2017, 1059 online and 365 paper responses were received. Although not all returns were via Citizens Panel, the majority were and a response rate of 36% was achieved. Although an easy-read version of the questionnaire was considered, the cost was felt to be disproportionate to the potential benefits this would bring so this was not pursued. One request for an easy-read version of the questionnaire was received and it was agreed that this person could submit their views as free text.

- 4.1.5 During the same period, a total of 178 community pharmacies, who were on the NHS England Pharmaceutical list were sent a paper questionnaire, asking them questions about the services they provide, any further services they would provide if commissioned to do so, opening times and accessibility to premises, including public transport links/accessible parking nearby. 154 responses (94 paper and 60 online responses) were received back during the survey period, which ran from 25th August 2017 to 22nd September 2017. This corresponds to an 87% response rate. A further two pharmacies were later identified outside the survey period as a result of cross checking of information, but were not included in the survey.
- 4.1.6 The draft PNA was then opened for wider consultation with community pharmacists and other stakeholders during the statutory period of 60 days, which ran from 4th December 2017 to 2nd February 2018. Although this consultation was not specifically targeted at the public, the Leeds Observatory is open to public use and anyone could, if they wished examine the document and provide feedback. A BAME focus group was also convened on the evening of 10th January 2018 to receive and incorporate further feedback from individuals from this group and other individuals with protected characteristics. These groups had not been well represented in the main community survey, despite additional measures being taken to engage them.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Although additional measures were put in place to try to reach our diverse community, we were not successful in attracting a good response from some minority groups such as BAME and LGBT groups. Whilst the BAME focus group agreed in the main with the findings of the PNA and enjoyed similar easy access, some members of the group knew individuals who could and would only use pharmacies where staff could speak to them in their own language.
- 4.2.2 The survey found some evidence that newly emerging communities may not be utilising community pharmacists as much as they might, but improvements to increase their access could be achieved by current providers. Continuing to exercise and extend where appropriate their expertise around Equality and Diversity will ensure that they are able to respond fully to meeting the needs of a changing and increasingly diverse population.

4.3 Resources and value for money

- 4.3.1 This piece of work has been done in house by Public Health colleagues with the assistance of a small project group. The only additional funding has been spent on essential items such as printing and postage for paper surveys and for final layout of the document, prior to publication.

4.4 Legal Implications, access to information and call in

- 4.4.1 There are no access to information and call in implications arising from this report.

4.5 Risk management

- 4.5.1 The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBs). The Act also transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.
- 4.5.2 The NHS Act (the “2006” Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health (DH) powers to make Regulations.
- 4.5.3 The Pharmacy Needs Assessment Project Group has worked to ensure that the 2018-2021 Pharmacy Needs Assessment is completed on time, to the required standard and compliance as in the above Acts.

5. Conclusions

- 5.1 The PNA 2018-2021 has now been compiled after a thorough and robust process, including a number of consultation measures. The Health and Wellbeing Board is asked to note the findings of the PNA.
- 5.2 Geographical service provision of pharmaceutical services in Leeds is generally very good. There is a good spread of pharmaceutical services, good access to pharmaceutical services and no current gaps in the provision of necessary services in the area of the Leeds Health and Wellbeing Board area population
- 5.3 There are no current gaps in the provision of other relevant services in the area of the Health and Wellbeing Board.
- 5.4 As of 1st January 2018, all areas of Leeds have a reasonable choice of pharmaceutical services
- 5.5 Although some parts of the Outer areas are less well covered, there are seven dispensing GPs in the Outer North East area and seven distance selling pharmacies across Leeds, which are available to the wider Leeds population.
- 5.6 There is some evidence that newly emerging communities may not currently be utilising community pharmacists as much as they might, but existing providers should be encouraged that their services were shown to be accessible. Continuing to exercise and extend where appropriate their expertise around Equality and Diversity will ensure that they are able to respond fully to meeting the needs of a changing and increasingly diverse population. Community staff and Public Health locality teams could also promote the role of community pharmacy for self-help advice amongst newly emerging communities.
- 5.7 The PNA has not identified any future needs which could not be met by pharmacies already on the pharmaceutical list, which would form part of related commissioning intentions.

6. Recommendations

6.1 The Health and Wellbeing Board is recommended to:

- Note the thorough processes undertaken to compile the PNA 2018-2021
- Note the findings and recommendations contained in the PNA 2018-2021
- Note that there are no current gaps in the provision of necessary services to meet the needs of the Leeds Health and Wellbeing Board area population.
- Note that there are no current gaps in the provision of other relevant services to meet the needs of the Leeds Health and Wellbeing Board area population.
- Note that the PNA has not identified any future needs which could not be met by pharmacies already on the pharmaceutical list, which would form part of related commissioning intentions.
- Notes that as of 1st January 2018, all areas of Leeds have a reasonable choice of pharmaceutical services
- Notes the follow up actions that have been taken, since the submission of the update paper submitted on 23rd November 2017.
- Approve the PNA document ready for publication and placing on the Leeds Observatory website <http://observatory.leeds.gov.uk/> by 1st April 2018.

7. Background documents

7.1 N/A

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How does this help reduce health inequalities in Leeds?

In terms of reducing health inequalities, community pharmacies are an easily accessible place for highly vulnerable groups, who have limited access to other health and care services, to receive self-care advice. The Pharmaceutical Needs Assessment has found that Leeds has good coverage of community pharmacy, for the whole population, especially in deprived neighbourhoods and for many vulnerable groups. There is some on-going work needed to ensure other vulnerable groups can get the most out of this valuable on the doorstep resource.

There are no current gaps in the provision of necessary services in the area of the Leeds Health and Wellbeing Board and there are no current gaps in the provision of other relevant services in the area of the Health and Wellbeing Board. There is some evidence that newly emerging communities may not currently be utilising community pharmacists as much as they might, but current providers could utilise Equality and Diversity training to improve their access. The PNA has not identified any future needs which could not be met by pharmacies already on the pharmaceutical list, which would form part of related commissioning intentions.

How does this help create a high quality health and care system?

The Pharmaceutical Needs Assessment has taken the views from both the public and community pharmacists to gain a view from the public on their perceptions of current quality of service and community pharmacists in terms of services currently provided, access to facilities and premises suitability for future purpose. This survey showed that public satisfaction with the quality of pharmaceutical services is high and the majority of the Leeds population who responded to the survey have very good or good access to services near their home.

How does this help to have a financially sustainable health and care system?

The PNA enables a view of current community pharmaceutical provision to ensure it is meeting the needs of the population in the Leeds Health and Wellbeing area. It also enables a judgement on whether this provision will continue to be adequate for the next three years. It has anticipated community pharmacies role and integration into new models of care and the changing health landscape to ensure that it continues to play a key part in improving the public's health.

Future challenges or opportunities

Funding challenges have been present, but so far this has not shown in this work as currently impacting on the services provided. However, it is possible that this will begin to show before a new PNA is produced.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	

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Leeds Pharmaceutical Needs Assessment 2018-2021

Leeds Health and Wellbeing Board

To be published 31st March 2018

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Executive summary

Statement and Purpose of PNA

A Pharmaceutical Needs Assessment (PNA) is a statement of the need for pharmaceutical services. Pharmaceutical services are provided by Pharmacies Dispensing Appliance Contractors, Distance selling pharmacies, Dispensing Doctors and Local Pharmaceutical Services.

The PNA has looked at the current provision of pharmaceutical services across Leeds, to assess whether it meets the needs of the population and to identify any potential gaps in service delivery.

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish a PNA and keep it up to date.

The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

If significant changes in the need for pharmaceutical services occur during the three years of the life of the PNA, then the Health and Wellbeing Board is required to publish a revised assessment as soon as is reasonably practicable. Supplementary statements to the PNA can be made if the provision of pharmaceutical services changes.

Process of producing PNA

The process of the PNA was broken down into four key stages:

- Scoping
- Analysis
- Formal consultation
- Final publication

During the development of the PNA, information was gathered about current service provision from a number of stakeholders, commissioners, community members and pharmacists themselves.

Summary of main findings

The PNA has found that Leeds has very good coverage of necessary pharmaceutical services with no gaps in provision. There are also no current gaps in the provision of other relevant services in the area of the Leeds Health and Wellbeing Board.

There is one less pharmacy since the 2015 PNA, but an increase in the number of distance selling pharmacies to seven. The Leeds Outer North East and Outer East areas have fewer community pharmacies within a one mile buffer zone of their

population, but in the Outer North East area there are seven dispensing GP practices to complement Community Pharmacy provision.

The majority of the Leeds population live within one mile of a pharmacy and 80% of the residents in the PNA public survey reported that availability of pharmacies in their area was very good (42%) or good (38%). 76% of residents said that the quality of pharmacies in their area was good or very good.

A very small minority of citizens reported some difficulty accessing out-of-hours pharmaceutical services.

Some newly-emerging communities may not be using available services as much as they might because of language and cultural barriers. By continuing to develop, exercise and extend where appropriate their expertise around Equality and Diversity, pharmacy teams can continue to respond fully to meeting the needs of a changing and increasingly diverse population.

The PNA having regard to likely changes to the number of people requiring pharmaceutical services, the demography of the Health and Wellbeing area, and the risks to the health and wellbeing of people in the area has not identified any future pharmaceutical needs within the next three years which cannot be met by providers currently on the pharmaceutical list.

If significant changes in the need for pharmaceutical services occur over the three year life of this PNA, then the Health and Wellbeing Board is required to publish a revised assessment as soon as is reasonably practicable. Supplementary statements to the PNA can be made, if the provision of pharmaceutical services changes.

Conclusions

The PNA concludes:

- There are no current gaps in the provision of necessary services in the area of the Leeds Health and Wellbeing Board
- There are no current gaps in the provision of other relevant services in the area of the Leeds Health and Wellbeing Board
- That as of 1st January 2018, all areas of Leeds have a reasonable choice of pharmaceutical services
- The PNA has not identified any future needs which could not be met by pharmacies already on the current pharmaceutical list which would form part of its related commissioning intentions

1. Introduction

The Public Health strategy for England “Healthy Lives, Healthy People” (2010) set out to put local communities at the heart of public health. It also stated that Health and Wellbeing boards would have a responsibility for producing pharmaceutical needs assessments (PNAs).

It recognised that:

“Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities.”

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish a PNA and keep it up to date.

The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

More recently, the NHS England Next Steps on the NHS Five Year Forward View report published March 2017 set out a detailed, costed package of investment and reform for primary care now through to 2020. It focuses on more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and better integrated with community and preventive services, hospital specialists and mental health care.

Most GP surgeries will increasingly work together in primary care networks or hubs, allowing them to share community nursing, mental health, and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. It will also involve working more closely with community pharmacists, to make fuller use of the contribution they make.

Therefore community pharmacies are viewed as an important and integral part of the NHS and being at the very heart of local communities have an important part to play in supporting local people maintain their health.

This PNA has assessed the current provision of pharmaceutical services across Leeds, to ensure it can meet the needs of the population over the three years from 1st April 2018 to 31st March 2021.

2. Main Findings

2.1 Geographical coverage and access

The PNA has found that Leeds has very good coverage of necessary pharmaceutical services with no gaps in provision. There are also no current gaps in

the provision of other relevant services in the area of the Leeds Health and Wellbeing Board.

There is one fewer community pharmacy since the 2015 PNA, but there are now seven distance-selling pharmacies, which is up from two reported in 2015. Therefore general infrastructure to increase access to pharmaceutical services has improved over the last three years.

The majority of the Leeds population live within one mile of a pharmacy and 80% of the residents in the PNA public survey reported that availability of pharmacies in their area was very good (42%) or good (38%). 76% of residents said that the quality of pharmacies in their area was good or very good.

The Leeds Outer areas have fewer community pharmacies within a one mile buffer zone of their population and fewer open for extended hours but the Outer North East area has seven dispensing GP practices and there are seven distance selling pharmacies across Leeds to complement community pharmacy provision.

A very small minority of citizens reported some difficulty accessing out-of-hours pharmaceutical services.

Some newly-emerging communities may not be using available services as much as they might because of language and cultural barriers. By continuing to develop, exercise and extend where appropriate their expertise around Equality and Diversity, pharmacy teams can continue to respond fully to meeting the needs of a changing and increasingly diverse population.

2.2 Service Provision

The 2015 PNA reported 181 pharmacies working within the national contract. In October 2017, there were 180 pharmacies working within the national contract.

2.3 Opening times

Many of the community pharmacies have opening hours that accommodate access for citizens outside of the usual 9am -5pm Monday to Friday period and twenty seven community pharmacies are contracted by NHS England to open for a minimum of 100 hours a week, an increase from twenty one in 2015.

2.4 Access to pharmaceutical services in Outer Community Committee Areas

There are 31,424 people who live in Lower Super Output Areas (LSOAs) where the centre of the LSOA is outside the one-mile buffer zone (**Appendix 1**). This means that they live more than 1 mile away from their nearest pharmacy.

The Leeds Outer areas have fewer community pharmacies within a one mile buffer zone of their population and fewer open for extended hours but the Outer North East

area has seven dispensing GP practices and there are seven distance selling pharmacies across Leeds to complement community pharmacy provision.

The vast majority of the public responding to the PNA survey did not report any major access issues. Feedback from citizens in the community survey and focus group found that a small minority had on occasion needed to travel further to reach a community pharmacy, but this does not constitute a gap in pharmaceutical services for the area.

Significant improvement work in transport is being planned and within 10 years, the Leeds Public Transport Investment Programme, with additional investment from the bus operators, will result in over 90% of core bus services running every 10 minutes between 7am and 8 pm. These improved transport links will enhance the current good access to an already wide range of essential and advanced services, which will support them and the wider health and social care system.

2.5 Implications of GP extended hours

91% of pharmacies responding to the PNA survey replied that the extended opening hours of GP surgeries (to seven days a week) had had no impact on the services they provide.

Of the 8% who had noticed an impact, a number of pharmacies were taking the opportunity to match these hours. Increased footfall was reported in a positive way, suggesting increased public access. This model has not yet been fully implemented, but is being rolled out in Leeds to ensure 100% coverage by the March 2019 deadline. Given the extent and coverage of current opening, any additional GP hours will be adequately covered by the existing network.

2.6 Service use

The majority of people responding to the PNA survey use their pharmacies for traditional medicines-based services and just under half visit their pharmacy every month. The dispensing service is used most, with 35% of individuals regularly and 39% sometimes using this service. Buying over-the-counter medicines is also popular: 16% of respondents regularly buy over-the-counter medicines and 63% do so sometimes.

Fewer people use their pharmacy to dispose of old or unwanted medicines, with 5% of people regularly and 44% sometimes using this service. The electronic prescription service is well used, with 40% of people regularly and 10% sometimes using this service.

Relatively few people said they access pharmacies for lifestyle support such as stop smoking advice, with only 1.4% using lifestyle support services regularly or sometimes. Slightly more (3.1%) regularly, or sometimes use pharmacies for advice on chronic obstructive pulmonary disease (COPD), which is a long-term, mainly smoking-related condition.

Less than 1% of the sample population use chlamydia screening regularly or sometimes; 0.8% use the emergency contraception service regularly and 1.8% sometimes.

However, limitations of the data mean it may not fully reflect the views of the smoking sub-population, the needs of the sexually active or childbearing population or the needs of those living in deprived neighbourhoods, where smoking and unplanned pregnancy prevalence is generally higher.

A lack of awareness as to what a community pharmacy can or is commissioned to provide was evident from both the community survey and the BAME focus group, which was convened during the 60 day consultation period so more effective communication channels and more frequent awareness-raising activities might be helpful, if pharmacies are to fully reach their potential.

2.7 Perceived gaps in service

Despite the public response, the most frequent perceived gap in services that pharmacy staff identified, and would provide if commissioned to do so, was sexual health, pregnancy testing and/or emergency hormonal contraception, together with weight management, smoking cessation/nicotine replacement. One stakeholder suggested that long term condition management, BP monitoring across the city, weight management and smoking cessation across the city may become a gap over the next three years.

However, following a comprehensive service review in 2015, a health needs assessment and stakeholder consultation, the stand-alone stop-smoking support service ceased in primary care and pharmacies in October 2017. The value of this contract was £4,000. Clients are now receiving this service as part of a comprehensive integrated lifestyle package, with the expectation that pharmacies will signpost to it where appropriate.

There is therefore no anticipated gap in terms of reduction of positive outcomes for the population of Leeds.

2.8 Vulnerable groups and newly-emerging communities

2.8.1 Disabled groups

143 (93%) of the 154 pharmacies responding to the survey are part of the Leeds Dementia Friendly Scheme. This is an unfunded but important goodwill scheme to help protect vulnerable individuals who are living with dementia.

122 (79%) pharmacies have unaided disabled access and 146 (95%) have floors that are accessible by wheelchair. 120 (78%) pharmacies have blue badge parking within 10 metres of the pharmacy and a smaller number have facilities and adaptations to help people with physical, visual or hearing impairments, as well as older and less mobile people, access their service.

One stakeholder reported some difficulties with regards to the deaf community accessing information at the time of collecting prescriptions. This can be adequately addressed by current pharmacies in terms of their equality and diversity considerations and does not constitute a need for further provision.

2.8.2 Gypsy Travellers

A small Health Needs Assessment in the Leeds Gypsy Traveller community in 2013 found that pharmacies (described as chemists by this group) were well respected, frequently used and accessible to them. All but 12% (6 individuals) had used the 'chemist' in the previous month and 89% (41 individuals) of those who got medicine from the chemist said its use was explained to them in a way they could understand and remember and that they had received helpful advice.

53% visited the chemist monthly, or more often, with 93% saying it was easy to find a chemist and 87% saying it was open when they needed it. 86% rated their last experience at the chemist as good to excellent. It was at that time suggested that pharmacists could provide a useful mechanism to communicate health messages to the Gypsy and Traveller community. Current providers are successfully engaging this vulnerable group, and they may wish to consider if there is some transferable learning to apply to other vulnerable groups.

2.8.3 Newly-emerging communities

There are residents from over 140 ethnic groups, speaking 170 different languages, residing in Leeds neighbourhoods. It is therefore possible that individuals from some newly-emerging communities are experiencing some limitations in access. 22% of pharmacies reported they have all their staff trained and 19% have some staff trained around equality and diversity. 58% of responding pharmacies reported having no staff with equality and diversity training.

The suitability of using family members for interpretation purposes was raised during the consultation period so community pharmacies, along with other frontline services such as primary care, may not be realising their full potential for engaging with and ensuring full access to pharmaceutical services for these communities.

2.8.4 Cultural differences

Existing community pharmacies may be able to put in place simple measures to help improve accessibility for highly vulnerable groups to receive self-care advice. This is likely to become more important with the advent of the new NHS Charging Regulations, effective from August 2017.

A study by Stevenson and Rao (2014) supported other evidence that BAME populations in England have a greater prevalence of illnesses such as diabetes and cardiovascular disease in comparison with their White counterparts. Ethnic variations have also been observed in access to health care, with 'intrinsic' cultural differences

such as language and literacy, as well as organisational factors in health services, offered as possible explanatory factors.

In this paper, it was suggested that engaging with existing community structures and leaders to deliver information and support in a language, style and model that is best suited to individuals and communities, would be an appropriate method of adapting to meet their needs.

2.8.5 BAME Focus Group- perceptions of services

A focus group of mainly African Caribbean and South Asian individuals from the LS7 (Chapeltown) area of Leeds was convened during the 60 day consultation period to ascertain whether this group had the same, or different experiences to the main survey group when using community pharmacies. Some individuals with other protected characteristics were also present. However, as an English speaking group, their perspective was very useful, but possibly not fully representative of other non-English speaking BAME groups.

Availability of community pharmacies for this group, was also very good, or good and none had had difficulty finding a pharmacy when they needed one. Similarly all agreed that the quality of services pharmacies provided was very good, or good.

Everyone could reach a pharmacy within ten minutes and many could reach it in much less time. No one felt that they had difficulty in finding a pharmacy open in the evening if they needed one and in their area they had a choice of several. One person said she didn't expect the pharmacy to be open in the evening as they, **like everyone else, 'were entitled to a life.'**

As with the main survey, the relationship that the pharmacy team had built up with them over many years was highly valued and this meant that if things went wrong, such as medicines not being available, or people needed to re-order medication well before holiday periods, issues could be quickly ironed out.

Several people said they appreciated the home delivery service, as in the main survey. Occasional issues around breaks in the supply chain were raised and medicines were not always available when the customer needed them. This was not considered to be the pharmacists fault, but possibly the supplier to the pharmacist. However, it was felt to let down the quality aspect sometimes.

This was also raised in terms of individuals obtaining repeat medicine if their usual pharmacy runs out. It was inconvenient having travelled to another pharmacy, some way away, only to be told that the pharmacy does not dispense the items they need.

The group stated that the services that pharmacies provide could be better publicised so more people would use them. One person had found it much more convenient to go to the pharmacists to have her blood pressure checked as unlike her surgery, she could drop in and get it done very quickly.

One person said that whilst the staff in the local pharmacy were very good, she felt that they did not reflect the make-up of the community that they served, even though

her (African Caribbean) community had been a substantial proportion of the Leeds community for many years. She felt that this needed action by the training establishments and the pharmacies that employ staff.

Another participant added that although he spoke fluently in and understood English, he was aware that some people he knew needed to go to certain pharmacists, so they could speak and be spoken to in their own language.

In terms of community pharmacies reaching vulnerable communities in Leeds, continuing to develop, exercise and extend where appropriate their expertise around equality and diversity will ensure that pharmacy teams can continue to respond fully towards meeting the needs of a changing and increasingly diverse population. It should also help improve the understanding of more vulnerable individuals around self-care.

It may also be useful for community pharmacies to make informal connections with third-sector agencies such as the 'Better Together' providers. These, and projects such as Migrant Access Point, are locality-based and work closely with newly-emerging communities. This may lead to better awareness of the services that community pharmacies can deliver, greater uptake of services and work towards achieving more of the aspirations of the Community Pharmacy Forward View (2016).

2.8.6 Substance users

163 community pharmacies in Leeds are contracted to provide a supervised opiate substitute consumption service and 133 pharmacies who replied to the survey confirmed they are providing this. Although few people in this survey said they used this service, there is comprehensive coverage of this service to meet the needs of Leeds citizens. The Outer North East has fewer providers but commissioners regularly monitor usage to ensure provision is where user needs are greatest.

There is evidence of success in this intervention. Analysis of supervised consumption was undertaken by Price Waterhouse Cooper for the Pharmaceutical Services Negotiating Committee in 2016. The analysis reported that each patient supervised generated in excess of £4,000 in value in 2015 alone, and a further £7,500 in the long term. This included savings to the NHS and the Criminal Justice system.

2.9 Non-commissioned services

Some community pharmacists stated they are providing services on a private or unpaid basis. 129 (84%) are providing free delivery of prescriptions to patients' homes and 137 (89%) are providing a prescription collection service, both of which were shown to be highly valued in the public survey responses.

112 (73%) offer blood pressure testing, which may detect untreated medical conditions but from the public survey, currently only 2.9% of people regularly and 9.6% sometimes use this service.

Blood pressure testing is being offered as a commissioned service from Leeds City Council from November 2017 in six community pharmacies located within deprived Leeds, such as Harehills, Bramley and Seacroft, with an aim to target 2,400 people over two years. This will increase access considerably in populations at risk, but awareness raising within the relevant communities will be essential.

Fewer, but fairly significant numbers of pharmacies provide diabetes checks/management (31%), inhaler reviews (32%) and palliative care medicines (24%).

One pharmacy was providing a falls prevention service. Although no other pharmacy highlighted it as a service they wished to provide if commissioned, it may highlight an opportunity for current pharmacy staff to incorporate 'making every contact count', particularly with middle-aged and elderly people, as part of a response to keeping the ageing population well.

2.10 Supporting primary care and public health 2015-2018

The 2015 PNA stated that Leeds was ambitious about growing the role of pharmacy teams in the delivery of integrated primary care and public health. There were opportunities to build on the services that pharmacies offer and to strengthen the links between pharmacies and other health and social care providers. Stakeholders also expressed the desire to work more closely and effectively with pharmacies to deliver improved health outcomes and closer integration of strategies.

NHS England is responsible for commissioning NHS primary care services in England, including community pharmacy services. The majority (90-95%) of total community pharmacy income comes from payment from NHS England, through the NHS pharmaceutical services contract and community pharmacies are a key part of the NHS. The NHS England funding settlement for 2015/16 was £2.8 billion, reducing to £2.687 billion in 2016/17.

Local Authorities and Clinical Commissioning Groups (CCGs) also commission services from community pharmacies, over and above those commissioned by NHS England. These services are described later in this assessment.

2.10.1 Changes to community pharmacy funding

Since the last PNA, there have been significant changes to the community pharmacy contractual framework. These changes are now being implemented and the impact of which is a reduction in the funding which community pharmacies receive. On 20th October 2016 the government announced that funding for NHS contractors providing services under the community pharmacy contractual framework was to be adjusted to £2.687 billion in 2016/17 and to £2.592 billion in 2017/18.

This represented a 4% reduction in funding in 2016/17 and a further 7.4% reduction in 2017/18.

Plans for change in the way funding was distributed were also announced:

- Establishment payments were to be phased out, and a range of dispensing fees to be amalgamated into a single activity fee.
- A Pharmacy Access Scheme (which was for 2017/18 only) was to be introduced to support services in isolated areas. The government published a list of 1,341 pharmacies that were to receive access payments.
- A £75 million Quality Payment Scheme was announced to award pharmacies extra funding based on how well they perform against criteria set out by the government.
- A Pharmacy Integration Fund to support closer working with other parts of the NHS.
- A further £42 million (which has subsequently been reduced to an unspecified amount), in addition to the 2016–2018 funding set out above was announced.

The changes took effect from 1 December 2016 so this needs assessment could be expected to identify/reflect any effects being felt as a result of those changes.

The pharmacy and community surveys did not show obvious evidence of these reductions in funding being a barrier to the day-to-day functioning of community pharmacies in Leeds, nor do they yet seem to be impacting significantly on customer experience. However, the impact may become more evident and continue to impact during and beyond the life of this PNA.

Some stakeholder feedback suggested that this may manifest in consolidation applications but it was felt that they can be managed through the current control of entry process and with very good current coverage, closure or consolidation of a pharmacy may not necessarily create a gap. During the preparation of the PNA, notice was received of three pharmacy closures in January 2018. This will reduce the number of community pharmacies in the relevant areas, but as they are positioned close to other sites, residents will still have a good choice of access.

2.11 Supporting primary care and public health 2018 – 2021

In Leeds, the full capacity of community pharmacy as described in the Community Pharmacy Forward View (2016) is developing, but has not yet been fully realised in Leeds. However, the PNA acknowledges that this untapped potential will allow community pharmacy teams to adapt and grow alongside the changing health landscape as capacity continues to build and be utilised.

At the time of responding to the PNA survey 52 (34%) of community pharmacies reported that they were a Healthy Living Pharmacy and a further 84 (55%) were working towards this. In January 2018 this had increased significantly to 149 community pharmacies achieving HLP status.

The ongoing process of developing New Models of Care will also progressively change the local health landscape, including re-assessing the role and potential of the community pharmacy team. This can be done through their existing contracts to ensure they contribute fully towards supporting the health of local people.

The GP Forward View (2016) highlights an investment of a further £2.4 billion a year by 2020/21 into general practice services. Practices are encouraged to work together in 'hubs' or primary care networks. This is because a combined patient population of at least 30,000–50,000 allows practices to share community nursing, mental health and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. It will also involve working more closely with community pharmacists, to make fuller use of the contribution they make.

The new Blood Pressure Wise initiative will also help to raise awareness of community pharmacy services, whilst further improving care for the public and patients. In time, it is possible that pressure on other parts of the NHS can be reduced through greater use of the skills of the community pharmacy team.

The demographic make-up of the Leeds population is changing, in terms of rapidly increasing numbers and a population that is becoming increasingly aged and increasingly diverse. As well as ensuring that the needs of the general public are met, it is therefore essential that the planning specifically considers the needs of particularly vulnerable groups, who may need additional support to engage fully with the current system.

This pharmaceutical needs assessment (PNA) has looked at the current provision of pharmaceutical services across Leeds, and found that it meets the needs of the majority of the survey population. With the changing health landscape in mind, it has identified a small number of areas where existing pharmacies could adjust practice to improve accessibility and reach, but there is currently no need for additional pharmacies. The geographical distribution is comprehensive and in terms of community pharmacy estate, the majority (92%) of premises were thought to be suitable for services planned in the future.

3 Background to PNA

People in England make 1.2 million visits to a pharmacy for health-related reasons every day. This presents a huge opportunity to support behaviour change through making every one of those contacts count (PHE, 2017). 'Utilising pharmacies to deliver commissioned services also has the potential to be hugely beneficial in the battle against high levels of avoidable illness and premature mortality' (RSPH, 2015).

A growing body of evidence shows that community pharmacies are successful when it comes to delivering health improvement initiatives. Community pharmacies are often embedded in some of the most deprived and challenging communities, providing daily contact for individuals seeking ad hoc and unplanned health advice, alongside picking up prescribed medicines, or purchasing over-the-counter health related products.

Pharmaceutical services are also important contributors to local communities through employment, supporting local people, improving health and wellbeing and playing an active role as a long-term partner in the local health care system. As New

Models of Care progress locally, the links between general practice, integrated teams and community pharmacies can be strengthened and become more formalised to provide a more 'joined up' and holistic response to Leeds communities' health needs.

The [Independent Review of Community Pharmacy Clinical Services](#) commissioned by the Chief Pharmaceutical Officer of NHS England in April 2016 helped inform the future provision of clinical pharmacy services. The recommendations from this report are being used by NHS England to inform its approach to the commissioning of NHS community pharmacy services.

The need for an in-depth pharmacy review was determined by the present context in which a pharmacy operates:

- the changing patient and population needs for healthcare, in particular the demands of an ageing population with multiple long-term conditions
- emerging models of pharmaceutical care provision from the UK and internationally
- the evidence of sub-optimal outcomes from medicines in primary care settings
- the need to improve value through integration of pharmacy and clinical pharmaceutical skills into patient pathways and the emerging new care models
- the need for service redesign in all aspects of care for a financially sustainable NHS.

3.1 Legislative requirements of the PNA

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep the PNA up to date. The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

PNAs are used by both the NHS and Local Authorities when considering which services can be, or need to be provided by community pharmacists.

NHS England commissions community pharmacy contractors to provide NHS pharmaceutical services through a Community Pharmacy Contractual Framework (CPCF). The CPCF consists of nationally commissioned essential services (services that all pharmacies must provide) and advanced services (national services that can be provided by all pharmacies once accreditation requirements are met) and locally commissioned Local Enhanced Services (commissioned by NHS England) to meet certain needs identified in the PNA.

Under the NHS regulations, a person who wants to provide NHS pharmaceutical services must apply to NHS England to be on a pharmaceutical list. NHS England will review the application and decide if there is a need for a new pharmacy in the proposed location, referring to the PNA to inform that decision. Exceptions to this

process include applications for needs not foreseen in the PNA or applications to provide pharmaceutical services online or via mail order only (known as distance selling).

3.2 Purpose of the PNA

The purpose of the PNA is to:

- Inform NHS England decisions on applications for new pharmacies and applications from current providers who would like to change their existing regulatory requirements. NHS England is required to refer to its local PNA.
- Help the HWB to work with providers to target services in areas of need and limit duplication of services where provision is adequate.
- Inform interested parties of the pharmaceutical needs in Leeds so that they can plan, develop and deliver pharmaceutical services that are appropriate for the local population.
- Inform commissioning decisions made by Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England.

4 Context of the PNA

4.1 National context of the PNA

The NHS Five-Year Forward View (2014) has recognised the key role of pharmacy, highlighting that there should be far greater use of pharmacists in prevention of ill health, support for healthy living, support for self-care for minor ailments and long-term conditions, medication review in care homes, and as part of more integrated local care models.

It states that a 'radical upgrade in prevention' is needed to improve people's lives and achieve financial sustainability of the health and care system. This national plan sits alongside the local health and wellbeing strategies and action plans, which focus at a local level on maximising prevention at scale, to improve the health of the population.

The Community Pharmacy Forward View (2016) sets out a clear role for the sector in any future model of care, focusing on three core domains for community pharmacy as:

- the facilitator of personalised care for people with long-term conditions
- the trusted, convenient first port of call for episodic healthcare advice and treatment
- the neighbourhood health and wellbeing hub.

The vision is that, in future, all community pharmacies will operate as neighbourhood health and wellbeing centres, providing the 'go-to' location for support, advice and resources on staying well and independent. Building on the development of the Healthy Living Pharmacy model, the safe and efficient supply of medicines managed by pharmacist-led teams will remain at the core of this community pharmacy offer.

However, this will now be recognised as just one component of a broader set of resources and services available within these health and wellbeing centres.

To ensure that these services are responsive, effective and valued, pharmacy teams will work closely with community leaders to identify and understand local assets and needs, to develop interventions and services based on this intelligence, to collect data on impact and outcomes, and use this to continually improve their offer. Recent changes in the way that services in the community are organised in Leeds may pave the way to making this way of working more likely in the future.

4.2 Local context of the PNA

Leeds is ambitious to be the best city for health and wellbeing. The vision of the Leeds Health and Wellbeing Strategy 2016–2021 is that Leeds, a city with a population of 760,000 people, will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The Leeds Health and Wellbeing Board is responsible for overseeing the achievement of this vision.

The Leeds Health and Wellbeing Strategy 2016–21 focuses on five outcomes:

- 1 People will live longer and have healthier lives.
- 2 People will live full, active and independent lives.
- 3 People's quality of life will be improved by access to quality services.
- 4 People will be actively involved in their health and their care.
- 5 People will live in healthy, safe and sustainable communities.

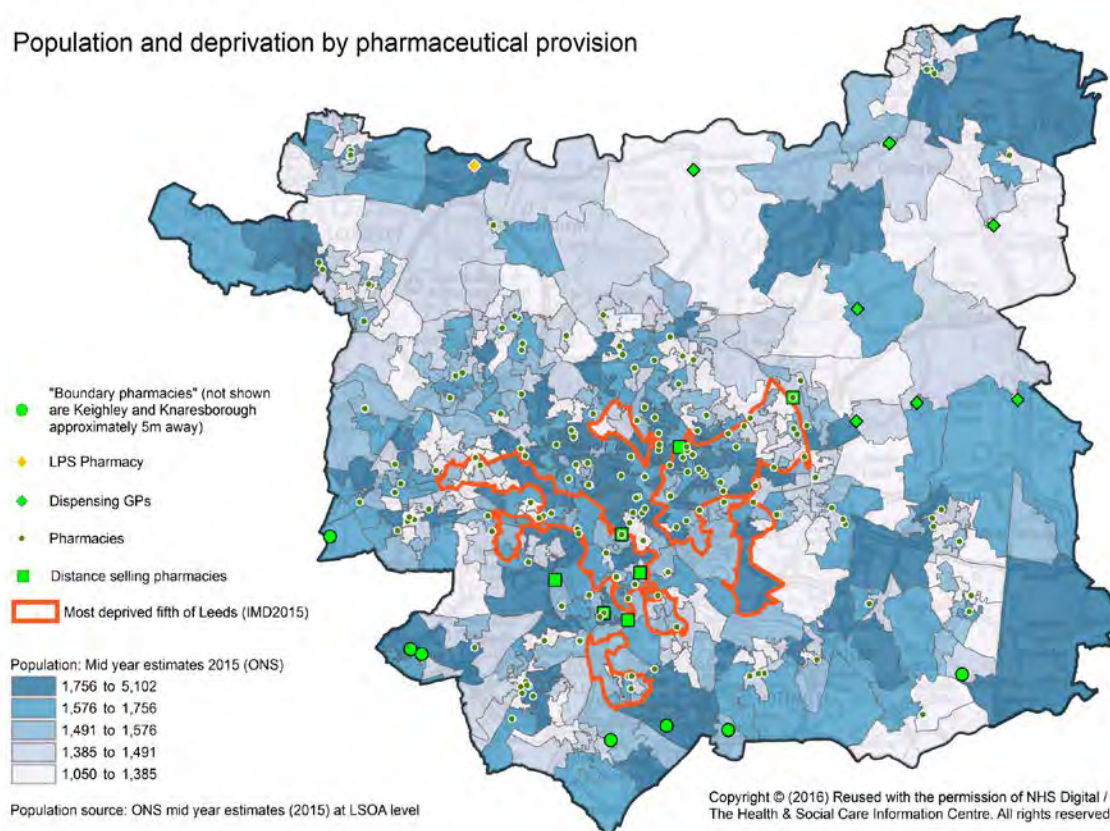
See: <http://www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf>

The PNA supports the delivery of the five outcomes above, particularly outcomes 1-4.

However, differences in wealth status lead to differences in health status. There are significant health inequalities between different communities in Leeds. This is most notably demonstrated by the 10-year difference in life expectancy between people living in Hunslet, a very deprived inner-city community, and those living in Harewood, a very affluent rural outer community.

People living in deprived areas typically have more years of long-term ill health and higher levels of poor mental health and wellbeing and mental illness. Significantly, in 2015/16, 20% of the Leeds population – almost 155,000 people – were classified as being in 'absolute poverty' (Leeds Best Council Plan 2017–18).

Figure 1. Leeds pharmaceutical services by deprivation



The statistics around differences in health status of the Leeds population by Community Committee area are shown at **Appendix 2** to **Appendix 11**.

Access to services is only part of the reason for this health gap, but ensuring that all members of the population can access appropriate healthcare and advice at the earliest opportunity is essential. This means that, as well as considering any geographical gaps in community pharmacy provision, the PNA has considered whether the services available are fully accessible to the culturally and ethnically diverse population of Leeds. Those from protected equality groups can experience services differently when compared to those who are not protected under the Equality Act 2010.

This is important as certain groups are more likely to develop certain medical conditions, hence perhaps requiring more support to manage these. Diabetes, for example is much more prevalent in South Asian and African Caribbean populations and hence may more likely be of significance to pharmacies in Harehills in the Inner East Community Committee of Leeds and Chapeltown in the Inner North East Community Committee area.

The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document by Williams and Varney et al (undated) shows that LGB&T communities are more likely to be experiencing health inequalities in relation to public health areas and preventing premature mortality. The higher prevalence of smoking, alcohol use and drug use, and lower uptake of screening programmes, are likely to contribute to increased risk of preventable ill health.

It suggests that LGB&T people experience barriers to accessing mainstream health and social care services due to a lack of understanding of their specific needs and a lack of targeted service promotion. Furthermore, this document suggests that fewer LGB disabled people are out to their GP or healthcare professionals than non-disabled LGB people. This means that community pharmacy teams need to be highly skilled to provide their service in a way that is sensitively attuned in order to fully meet the diverse needs of their local community.

Community pharmacies also need to be sensitive to the population's diversity in terms of age-by providing a service to an increasingly ageing population as well as meeting the needs of the young people that reside in or travel to Leeds during a typical year. Leeds has five Universities, University of Leeds, Leeds Beckett, University of Law, Leeds Arts University and Leeds Trinity. Together with a number of other institutions, this means that Leeds has the fourth largest student population in the country.

The Leeds Health and Wellbeing Strategy 2016–2021 aims to put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high-quality services. The Leeds Health and Wellbeing Board is responsible for overseeing the achievement of this vision and, as a key part of the local health infrastructure, community pharmacies are ideally placed to help provide this.

4.3 New developments in GP and primary care services

Leeds has a history of success in supporting communities and neighbourhoods to be more self-supporting, leading to better wellbeing for older citizens and children, whilst using resources wisely to ensure that help will always be there for those who cannot be supported by their community. The Leeds Health and Care Plan (2017) highlights that the health and wellbeing of citizens in Leeds will be improved through more efficient services, investing more thought, time, money and effort into preventing illness, and helping people to manage ongoing conditions themselves. This will help prevent more serious illnesses that may result in expensive hospital treatment.

It starts with recognising how communities can keep people healthy through connecting them with activity, work, joining in with others and things that help give them a sense of wellbeing. GPs, community health and care services, and other community services such as voluntary groups, can focus better on keeping people healthy and helping them to manage their own health through working more closely together as one team. The city is therefore developing innovative GP services.

These approaches include new partnerships and ways of organising community and hospital skills to be delivered in partnership with local GPs and closer to home. This is happening at the same time as patients are being given access to extended opening hours, with areas of the city having GPs open 7 days per week.

It is also possible to make better use of health information to target those at risk of getting ill and so intervene earlier. Leeds is the first major UK city where every GP and healthcare and social worker can electronically access the information they need about patients through a joined-up health and social care record for every patient registered with a Leeds GP. This does not currently extend to community pharmacy staff, however.

The city is currently looking at how it can further enhance its integrated offer within the community and is enhancing the current Integrated Neighbourhood Team Model to include primary care. This new model is being referred to as 'Local Care Partnerships'.

Health and care services working in neighbourhoods will work in partnership as one team and look after all of an individual's needs. They will also support citizens to focus on the things that are most important to them in improving their wellbeing. This will mean that the whole experience of our local health service could change over time. There may be more joined-up help for housing, benefits and community activities. GPs may need to work more collaboratively to share resources, staff and premises to make sure they can work in this new way. Other health, care and community services – and, potentially, community pharmacies – will need to join in with the approach.

This change would mean training the existing and future workforces to work with citizens and with each other in new ways. The approach will bring some of the expertise of hospital doctors right into community services, which would mean less referral to specialists and ensure that as much as possible is done in the community. This should mean fewer visits to hospital for fewer procedures, but the hospital services will still be there when citizens and their family need them.

This development will help deliver the Leeds ambition to grow the role of pharmacy teams in the delivery of integrated primary care and public health as set out in the 2015 PNA. The opportunities to build on the services that pharmacies currently offer, and to strengthen the links between pharmacies and other health and social care providers, are beginning to create a more solid foundation for creating strong local health systems.

4.4 Healthy Living Pharmacies (HLPs)

In 2015, the Health and Wellbeing Board encouraged pharmacies to join the West Yorkshire Healthy Living Pharmacies programme (part of the National Healthy Living Pharmacies). HLPs aim to reduce health inequalities by adhering to quality criteria around workforce development, engaging with the local community and adhering to principles of a health promoting environment. The Healthy Living Pharmacy (HLP)

Level 1 helps to reduce health inequalities by evidencing adherence to the following quality criteria:

- Workforce development – develop the pharmacy staff so they are well-equipped to embrace the healthy living ethos and proactively promote health and wellbeing messages.
- Engagement – demonstrate that the pharmacy team is actively engaging with the local community, including the public, health and social care professionals, commissioners and other local organisations (e.g. the voluntary sector).
- Environment – have a health-promoting environment that embraces the ethos of a Healthy Living Pharmacy, including an atmosphere created by premises as well as staff attitudes and actions. The environment should also ensure confidentiality for service users.

4.4.1 Quality Payments Scheme

Achieving HLP level 1 (self-assessment) is now a Quality Payment criterion for the Quality Payments Scheme 2017/18.

In 2017, 52 (34%) of the 154 pharmacies replying to the PNA survey had achieved HLP Level 1 and 84 (55%) were working towards HLP status. Only 13 (8%) were currently not working towards achieving HLP status. In January 2018 this had increased significantly to 149 pharmacies achieving Healthy Living Pharmacy status. This provides an excellent base on which to build aspirations for the neighbourhood health and wellbeing hubs and reduce health inequalities.

4.5 Local Care Partnerships

The Local Care Partnerships and the Leeds Health and Care Plan continue to highlight the necessity for self-care in communities. The importance of all individuals having a good understanding of how to stay healthy when the GP is not available, or a condition does not require a GP's attention, means that community pharmacies are ideally placed to help increase that understanding.

4.6 Future planning

As described above, the Leeds picture is similar to that stated in the Independent Review of Community Pharmacy Clinical Services (2016). Whilst progress has been made towards implementing this vision, there is still untapped potential to improve care for patients, to reduce pressure on other parts of the NHS and to provide improved services to patients through making better use of the skills of the community pharmacy team.

The roll-out of extended services at weekends and evenings across the whole of the Leeds population – with an incremental programme from March 2018 (and some additional hub locations over the winter period) – may impact on community pharmacies by increasing footfall and demand from patients.

Future aspirations are against a background of reduced government funding for community pharmacies, so it may prove challenging to ensure that the New Models of Care fully realise their ambitions. However, the current proposals to increase access to GP services out of hours will be adequately met by the current pharmacy contractors, since many are already open beyond GP opening hours. By working more closely and effectively with pharmacies, improved health outcomes and closer integration of strategies is possible.

4.7 Definition of NHS pharmaceutical services

Pharmaceutical services as defined in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 include:

- **Essential services.** These are services which every community pharmacy offering NHS pharmaceutical services must provide (as described in Schedule 4, Part 2 of the Regulations). These include the dispensing of medicines, repeat dispensing, signposting, public health campaigns/promotion of healthy lifestyles, disposal of unwanted drugs and support for self-care. These services are negotiated and funded at a national level.
- **Advanced services.** These are services which community pharmacy contractors and dispensing appliance contractors can choose to provide, as long as they meet the requirements set out in the Secretary of State's Directions. Currently, these advanced services include medicines use reviews (MUR), prescription interventions, the new medicine service (NMS), flu vaccination, NHS urgent medicines supplies advanced service (NUMSAS), appliance use reviews (AUR) and the stoma customisation service provided by dispensing appliance contractors and community pharmacies.
- **Enhanced services.** These services can only be commissioned by NHS England. Services can include anti-coagulation monitoring, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on-demand availability of specialist drugs, and out-of-hours services.

The regulations do not cover 'pharmaceutical services' commissioned by local authorities and CCGs. Although not a mandatory element of a PNA, where the need for a service is clear, it has been stated in this assessment to help guide local commissioning.

4.8 Types of pharmaceutical provider

Several types of providers can be added to the pharmaceutical list. These include:

- Pharmacy contractors – independent contractors working individually or as groups of pharmacies who provide NHS pharmacy services in community pharmacy settings.

- Dispensing appliance contractors – appliance suppliers are a subset of pharmacy contractors who supply appliances such as incontinence aids, dressings, bandages, etc. on prescription. They cannot supply medicines.
- Dispensing doctors – medical practitioners who are authorised to provide drugs and appliances in designated rural areas known as ‘controlled areas’.
- Local pharmaceutical services (LPS) contractors – provide services specifically negotiated to meet local need; this must include an element of dispensing.
- Distance-selling pharmacies – although not covered by the same market entry system that relies on the PNA, distance-selling pharmacies are able to supply medicines to the population. They can only offer essential services remotely – not face-to-face.

4.9 Scope of assessment

The PNA will meet the requirements identified in Schedule 1 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and is summarised below:

- Current provision of necessary services – this includes services inside the Leeds Health and Wellbeing Board (HWB) geographical area as well as services that sit outside the Leeds HWB area, yet service its population.

This requirement also includes the need to map current provision of services by:

- Pharmacies.
- Distance-selling pharmacies.
- Dispensing appliance contractors.
- Dispensing doctors.
- Gaps in provision of necessary services – this includes current and future gaps in pharmaceutical health and also gaps by service type. For example, if a new housing development is planned in the Leeds Health and Wellbeing area then additional pharmaceutical services may need to be considered.
- Current provision of other relevant services – this includes services both inside and outside of the Leeds Health and Wellbeing area boundaries that are not meeting an identified need but do secure improvements or better access to services.
- Service provision that would secure improvements and better access if provided. This is a statement about identifying services that are not currently being provided but which will be needed to secure future improvements in pharmaceutical services.
- Other services – any NHS services provided or arranged by the HWB, NHS England, a CCG or NHS (Foundation) Trust which affect the need for pharmaceutical services, for example a large health centre providing a stop-smoking service.

4.10 Excluded from the PNA

The PNA's scope is defined by its regulatory purpose. Therefore, pharmaceutical services in prisons are excluded from this assessment as providers contract directly from the prison authorities.

4.11 Identification of health needs

The PNA used a number of documents to identify local health priorities. A health profile for each of the ten Community Committee areas has been produced and these are shown at **Appendix 2** to **Appendix 11**. The tables below show that there is wide variation in health experience across Community Committee areas. There is also considerable variation within the Community Committee areas.

4.12 Inner Community Committee areas of Leeds

The Inner Community Committee areas of Leeds have the most concentrated deprivation and have health statistics that are the worst amongst the 10 Community Committees. However, when taken to smaller geographies (MSOA level) within individual Community Committee areas, there are sometimes also worst health outcomes than in Deprived Leeds.

Table 1. Life expectancy at birth 2014–16, ranked Inner Community Committees

Community Committee	All	Males	Females
Inner East	76.9	74.5	79.7
Inner South	77.4	76.0	78.9
Inner West	79.0	76.6	81.6
Inner North East	80.8	79.4	82.1
Inner North West	81.1	79.7	82.5
Leeds	80.9	79.1	82.7
Deprived Leeds	76.6	74.4	79.0

Source: Community Committee profile, August 2016

Life expectancy in the Inner East area of Leeds is comparable to that of Deprived Leeds but Inner East, Inner South and Inner West have life expectancy considerably lower than in Leeds as a whole and the Inner North areas (Table 1).

Whilst the all-cause premature (under 75 years) mortality rates are slightly lower than Deprived Leeds in all Inner Community Committee areas (Table 2), they are considerably higher than Leeds as a whole. The highest MSOAs in all three areas show premature mortality that is significantly higher than Deprived Leeds, especially Inner West.

Table 2. All-cause mortality (under 75 yrs) 2012–16, ranked Directly Age Standardised Rate (DSRs) per 100,000

Community Committee	All	Males	Females
Inner East	542	660	417
Highest MSOA	617	738	528
Inner South	523	617	422
Highest MSOA	617	723	528
Inner West	465	569	358
Highest MSOA	692	763	603
Leeds	356	427	286
Deprived Leeds	573	683	459

Source: Community Committee profile, August 2016

This is also the case for premature mortality from cancer (Table 3) where every category for each Inner area is higher than that of Leeds as a whole. The highest MSOAs in each area also exceed the rate found in Deprived Leeds.

Table 3. Cancer mortality (under 75yrs) 2012–16, ranked DSR per 100,000

Community Committee	All	Males	Females
Inner East	203	233	175
Highest MSOA	254	315	221
Inner South	194	205	183
Highest MSOA	363	333	434
Inner West	174	204	143
Highest MSOA	232	277	204
Leeds	147	164	133
Deprived Leeds	206	230	181

Source: Community Committee profile, August 2016

This situation is also true of the respiratory disease figures (Table 4), which are particularly high in the highest MSOA of Inner South. This is highly relevant to preventive work around smoking cessation and lifestyle support, as well as asthma and COPD management.

Table 4. Respiratory disease mortality (under 75 yrs) 2012–16, ranked DSR per 100,000

Community Committee	All	Males	Females
Inner East	61	70	52
Highest MSOA	85	99	102
Inner South	58	61	56
Highest MSOA	142	150	129
Inner West	53	58	48
Highest MSOA	95	110	94
Leeds	32	35	29
Deprived Leeds	66	74	58

Source: Community Committee profile, August 2016

4.13 Outer Community Committee areas of Leeds

Table 5. Life expectancy at birth 2014–16, ranked Outer Community Committees

Community Committee	All	Males	Females
Outer East	81.3	79.1	83.3
Outer North East	85.3	83.5	87.0
Outer West	80.7	79.0	82.2
Outer North West	83.8	82.0	85.5
Outer South	81.7	80.2	83.1
Leeds	80.9	79.1	82.7
Deprived Leeds	76.6	74.4	79.0

Source: Community Committee profile, August 2016

The life expectancy table (Table 5) shows that all Outer areas, with the exception of Outer West, have better life expectancy than Leeds as a whole and very much better than Deprived Leeds.

Table 6. All cause mortality (under 75 yrs) 2012–16, ranked Directly Age Standardised Rate (DSRs) per 100,000

Community Committee	All	Males	Females
Outer East	327	396	263
Highest MSOA	551	723	458
Outer North East	234	285	186
Highest MSOA	489	583	401
Outer West	346	418	278
Highest MSOA	617	701	528
Outer North West	270	324	220
Highest MSOA	379	454	310
Outer South	325	372	279
Highest MSOA	432	525	366
Leeds	356	427	286
Deprived Leeds	573	683	459

Source: Community Committee profile, August 2016

The all-cause mortality rates per 100,000 people in the Outer areas (Table 6) are also generally much lower than Deprived Leeds and lower than Leeds as a whole. There is however, some variation across each Community Committee area. Outer East's highest MSOA has a male rate considerably above that of Deprived Leeds and Outer West has an MSOA that is considerably higher than Deprived Leeds across all three measures.

Table 7. Cancer mortality (under 75 yrs) 2012–16 ranked DSR per 100,000

Community Committee	All	Males	Females
Outer East	138	159	120
Highest MSOA	216	282	192
Outer North East	111	124	100
Highest MSOA	205	234	179
Outer West	147	156	140
Highest MSOA	245	239	253
Outer North West	126	146	108
Highest MSOA	162	216	158
Outer South	145	154	137
Highest MSOA	161	191	193
Leeds	147	164	133
Deprived Leeds	206	230	181

Source: Community Committee profile, August 2016

The premature cancer mortality rates (Table 7) are more in line with those of Leeds as a whole but many of the highest MSOAs exceed the Deprived Leeds rates. They are, however, lower than those seen in the Inner Community Committee areas.

Table 8 Respiratory disease mortality (under 75 yrs) 2012–16 ranked DSR per 100,000

Community Committee	All	Males	Females
Outer East	24	29	20
Highest MSOA	52	85	38
Outer North East	14	15	13
Highest MSOA	50	61	40
Outer West	32	35	29
Highest MSOA	60	71	57
Outer North West	18	20	16
Highest MSOA	42	46	44
Outer South	29	29	28
Highest MSOA	49	54	62
Leeds	32	35	29
Deprived Leeds	66	74	58

Source: Community Committee profile, August 2016

In terms of respiratory disease, the Outer East, Outer North East and Outer North West have levels lower than those of Leeds as a whole and much lower than Deprived Leeds. However, Outer West has levels approaching those of Deprived Leeds and the Outer South's highest MSOA has higher female mortality than Leeds or Deprived Leeds. Outer North East has much lower levels than Leeds and Leeds Deprived.

There is a wealth of Leeds-related health and wellbeing information on the Leeds Observatory which is not replicated in the PNA. Go to: <http://observatory.leeds.gov.uk/> The PNA should be read in conjunction both with the profiles placed there and also the Community Committee profiles at **Appendix 2** to **Appendix 11** to gather more detailed information on specific area and health needs.

4.14 Population growth

Leeds is a growing and increasingly diverse population with the population growing by 5.3% between 2005 and 2015. Section 2 of the Core Strategy Profile of Leeds District highlights an anticipated growth of the population of Leeds from 755,136 in 2010 to 860,618 by 2028.

This raises major challenges for Leeds in seeking to meet the housing needs of this growing and ageing population over this time period. We are also living longer in Leeds than ever before which is in agreement with the findings of the Independent Review of Community Pharmacy Clinical Services (2016). The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030. This is an incredible achievement, but also means that the city is going to need to provide more complex care for more people (Leeds Health and Care Plan 2017).

There are plans to build new housing developments to accommodate some of this anticipated population growth. The Leeds City Council draft Site Allocations Plan needs to identify land to accommodate 66,000 dwellings. A further 4,000 poor-quality homes will be replaced. The Core Strategy Policy SP7 further breaks down the total housing target for Leeds as follows:

Table 9. New housing developments planned by 2028

Area of Leeds	Number	%
Aireborough	2,300	3.0%
City Centre	10,200	15.5%
East Leeds	11,400	17.0%
Inner Area	10,000	15.0%
North Leeds	6,000	9.0%
Outer North East	5,000	8.0%
Outer North West	2,000	3.0%
Outer South	2,600	4.0%
Outer South East	4,600	7.0%
Outer South West	7,200	11.0%
Outer West	4,700	7.0%
Total	66,000	100.0%

The Leeds Core Strategy (adopted 2014) suggests that 70% of the new housing will be in existing settlements, which makes it likely that this housing expansion will increase pressure on GP service provision and increase visits to community pharmacies. However, with the current suggested ratio of one GP to a patient list size of 1,800 – 2,000 patients, it is unlikely that the pressure will be sufficient to create a gap in pharmaceutical provision over the life of this PNA.

There is very good coverage of community pharmacies in the Inner areas of Leeds, even though a substantial proportion of the proposed homes will be close to deprived communities, where need for health services is arguably much greater. GP audits (2015) showed that, in 2014, 166,765 out of 817,253 Leeds residents who were GP registered were recorded as living in deprived areas.

This is likely to include an increasing proportion of newly-emerging BME populations, as housing costs are lower in these areas. In 2016, 16.1 per 1,000 of new GP registrations were made by people who previously lived abroad compared to a Yorkshire and Humber average of 9.5 per 1,000 (Leeds Local Migration Profile 2016).

In accordance with the Core Strategy Policy P9, housing developers are encouraged to consult with NHS Leeds CCG Partnership in relation to proposed housing developments to establish whether there is any potential impact on local health care/primary care provision, which could include pharmaceutical services.

A map showing the future housing developments against pharmacies is shown at **Appendix 12**.

4.15 Localities for the PNA

The PNA has looked at community pharmacy provision across the whole HWB area, with Community Committee boundaries identified on maps to highlight local need. The 10 Community Committees have been selected as the localities for analysis and discussion for a number of reasons.

Firstly, the Community Committees hold meaning for the local authority and the elected members that represent the constituent wards in each area. Secondly, Community Committees are also used as convenient aggregate areas within other needs assessments and reports.

They provide useful geographies for comparing differences in health status between Community Committee areas but also by Ward which make up the Community Committee areas. Differences at the smaller Middle Super Output Areas (MSOA) level within each Community Committee can also be examined to compare statistics within and between Area Committee areas. Thirdly, the Community Committees coincide with the deprivation fault line that demonstrably separates the five deprived Inner areas and the five more affluent Outer areas.

The map which shows the deprived neighbourhoods across the Leeds area is shown earlier in this assessment at Figure 1.

5 PNA process and consultation

The process of developing the PNA was broken down into four key stages:

- 1 Scoping
- 2 Analysis and draft report writing
- 3 Formal consultation
- 4 Final publication

5.1 Stage one: scoping

This stage involved identifying all appropriate stakeholders and current commissioners and seeking their views and input, with a specific focus on current provision, perceived gaps in provision, and future developments within the health landscape and for pharmaceutical services.

This information was used to build a picture of need and future potential, but also to inform development of the pharmacist and public questionnaires so that perceived gaps and potential could be checked out and corroborated by pharmacists and public experience.

A project team was convened to ensure that the PNA covered all requirements, and to support it to completion. The project team consisted of:

- Liz Bailey (Head of Public Health)
- Rachael Oakley (Public Health Governance Manager)
- Richard Dixon (Public Health Intelligence Manager)
- Adam Taylor (Senior Information Analyst)
- Community Pharmacy West Yorkshire - Ruth Buchan FFRPS (Chief Executive Officer)
- NHS England - Samantha Cavanagh (Primary Care Manager)
- NHS Leeds Clinical Commissioning Groups Partnership - Sally Bower (Patient Safety and Medicines Optimisation Team)
- Healthwatch Leeds - Tatum Yip (Community Project Worker)

Other colleagues were consulted as and when required.

5.2 Community pharmacists consultation

A community pharmacy questionnaire was drawn up and distributed in paper format to 178 community pharmacies in Leeds and boundaries that appeared on the NHS England pharmaceutical list. Opening times were checked against the NHS Choices website and a request made for the receiving pharmacy to confirm or amend their current hours and address. This helped to ascertain out-of-hours services and ensure that the hours listed on the NHS Choices website are up to date and accurate so that members of the public are able to find the assistance they need quickly.

The questionnaires aimed to gain a current picture of the services that community pharmacists are providing. A public questionnaire was also developed and

distributed via the Leeds Citizens' Panel and a number of other routes to try to capture the public's views on availability, access and use of community pharmacies.

During the survey period 25 August to 22 September 2017, 154 responses were received (87% response rate) from the 178 community pharmacies on the NHS England pharmaceutical list – 94 paper responses and 60 online responses. A further two pharmacies were identified during later cross-checking of service provision but as this was outside the survey period and the survey link was no longer available, these have been included where services are known, but not in the self-reported aspects of the analysis.

The questionnaire asked pharmacy staff questions which aimed to identify their contractual status, provision of services and ease of access to those services.

Although there was considerable emphasis on physical access to community pharmacy services, such as disabled access, the questionnaire also aimed to identify any non-physical barriers that may deter some members of our increasingly diverse population from accessing the service. This included the availability of multi-lingual staff/resources and awareness of the needs of people according to their sexual orientation or religious beliefs.

The questionnaire also asked pharmacy staff to identify any gaps in provision. A summary of the pharmacy survey results is provided at **Appendix 13**.

5.3 Stakeholder input

A letter and reporting template was sent on behalf of the HWB to a number of stakeholders. The template sought to seek each organisation's view on:

- current pharmaceutical services provision within the Leeds HWB area
- perceived gaps in pharmaceutical services provision (either currently or which they foresee within the next three years)
- services operating outside the Leeds HWB area which they consider will impact on pharmaceutical services within the district
- any other factors they feel the HWB should consider when developing the PNA (e.g. any plans within their organisational strategy that may impact upon future pharmaceutical service provision)
- any future commissioning intentions that will impact upon pharmaceutical services.

The stakeholder letter was sent to a representative from each of the following organisations:

- Community Pharmacy West Yorkshire
- Leeds North, Leeds West and Leeds South and East Clinical Commissioning Groups (now NHS Leeds Clinical Commissioning Groups Partnership)
- Healthwatch Leeds
- Leeds Local Medical Committee (LMC)

- Leeds Teaching Hospital Trust
- Adult Social Care, Leeds City Council
- Children's Services, Leeds City Council
- the Third-sector representatives on the HWB
- Carers Leeds
- Leeds Involving People
- Tenfold
- MESMAC
- Local Professional Network (LPN) for Pharmacy.

Stakeholder responses were received from Community Pharmacy West Yorkshire, Healthwatch, NHS Leeds Clinical Commissioning Groups Partnership, Leeds Involving People and LCC Adult Social Care. A further individual response from a citizen was also received on this format from Age UK because the person was unable to access the community questionnaire.

The Local Medical Committee (LMC) sent a paper response to the address requested, but unfortunately this failed to arrive so could not be used. However, an LMC representative stated that the LMC agreed with a response sent in by Community Pharmacy West Yorkshire, so this was used.

Stakeholders were asked to rate the availability, quality and accessibility of community pharmacies in Leeds and this was on the whole rated as very good or good; there was one quality and accessibility rating as 'okay'.

Most stakeholders were not aware of any gaps in the service now and felt it unlikely that there would be any gaps in the next three years. However, one stakeholder felt that long-term conditions management, blood pressure monitoring across the city, and weight management and smoking cessation services across the city, would be a commissioning gap within the next three years. However, as this service has just been re-commissioned after a Health Needs Assessment and review process, it will be necessary to collect and analyse One You Leeds and Blood Pressure Wise data before a true assessment can be made.

There was awareness that the system integration that the CCGs are starting to work up within the Leeds HWB area will eventually include community pharmacy as part of a wider provider network. Therefore the PNA project group was asked to consider the changing health and social care landscape, the accountable care system and the Local Care Partnerships, which will be working closely with community pharmacy in the future.

Community pharmacies were considered to be well distributed across the whole of Leeds in high streets, supermarkets, community locations, next to and remote from GP surgeries – all embedded within the communities they serve. They were considered to be flexible and adaptable; they can (and do) change to meet new challenges and offer additional services where additional need is identified.

It was felt that community pharmacy is well placed to offer all of the services listed in question 5 of the consultation template, particularly people having good access to wrap around support in their own community. Although there will be changes to health and social care within the next three years, it was felt that the current community pharmacy network is likely to be able to meet these additional requirements.

It was pointed out that some pharmacy services are only commissioned from a set number of pharmacies and that this is limited by the commissioner. As some pharmacies are clearly providing some services outside the commissioning framework, for example prescription delivery (which is neither funded nor a contractual obligation), it is clear that this does not reflect on the will of community pharmacies to provide the service.

The funding changes imposed on community pharmacies by the Department of Health in 2016/17 and beyond, was not raised in the feedback from pharmacists. However, there was a perception from one stakeholder that it will have impact on community pharmacies. It was suggested that each situation should be individually assessed to determine whether a gap will be created or not.

On the service side, some issues were reported in terms of customer inconvenience, such as turning up to collect repeat prescriptions that had not been issued. It was unclear as to whether this is due to customers misunderstanding or internal/external systems failure.

A need to better communicate the services on offer to both patients and professionals was highlighted. There was a stakeholder perception that people are not aware of the full service that the pharmacy provides. This issue was raised a number of times during the PNA.

One stakeholder highlighted issues around dispensing and the deaf community, particularly if a British Sign Language interpreter is absent, the deaf patient is unable to ask questions about their medication.

There was an indication that some out-of-hours difficulties had been experienced. One stakeholder suggested that the HWB should consider making a 24-hour on-call pharmacy service available out of hours. However, the out-of-hours GP service has access to essential drugs that can be given to patients at times when a pharmacy is closed. This is a limited list, but it is nationally determined. It is considered that other drugs, not currently on the list, are not urgently needed and that clinically a patient can wait until a pharmacy opens.

5.4 Services provided across other local authority areas

The HWB and stakeholder feedback found no services operating within or outside the Leeds Health and Wellbeing area that are impacting, or will in the future impact, on the capacity of community pharmaceutical services for Leeds residents.

5.5 Public engagement

An electronic and paper questionnaire was developed and distributed through the Leeds City Council's Citizens' Panel. 3,350 residents were invited to respond online while 600 residents were sent a paper questionnaire. Additional measures were taken to capture the views of young people – via youth clubs and LCC Young People's Voice, Influence and Change Team – and those of BME groups – through Healthwatch, the LCC Communities Team and Leeds Gypsy Traveller Exchange (GATE). Tweets were also shared through various council twitter accounts, including @LeedsCC_News @HWBBoardLeeds @BetterLivesLds @OneYouLeeds. A range of others were tagged to get their involvement too.

An easy-read version of the questionnaire was considered, but the cost was felt to be disproportionate to the potential benefits so this was not pursued. Only one request for an easy-read version of the questionnaire was received and this person submitted their views as free text.

In the live survey period between 22nd August and 29th September 2017, 1059 online and 365 paper responses were received. Although not all returns were via Citizen Panel, the majority were and an approximate response rate of 36% was achieved.

A summary of the community survey results is shown at **Appendix 14**.

5.6 Stage two: analysis and draft report writing

The content of the PNA was produced as a result of collecting, analysing and compiling information from published national and local statistics and reports. Commissioners were asked about the services they commission and community pharmacists about the services they currently provide. This information was mapped to show the geographical spread of each commissioned service and also opening hours of the pharmacies to assess out of hours coverage and accessibility.

A community survey and a focus group added citizen's actual experience of availability, access to and satisfaction with community pharmacy services and a stakeholder consultation provided information around services within and outside the HWB, which could impact on community pharmacy provision and any perceived gaps now or in the next three years.

The draft document was shared with a number of stakeholders prior to draft publication.

5.7 Stage three: Formal consultation

The draft PNA was published on the Leeds Observatory website from 4 December 2017 to 2 February 2018: <http://observatory.leeds.gov.uk>.

This met the required formal consultation period of 60 days. The link to the draft was sent to all mandatory stakeholders on the first day of consultation, in line with Department of Health regulations and are shown below:

- All Elected Members
- All Leeds community pharmacists
- Neighbouring Health and Wellbeing Boards of Bradford District, Craven, Calderdale, Kirklees, Harrogate and Wakefield
- Third Sector representative of Leeds Health and Wellbeing Board
- Representatives of Leeds Clinical Commissioning Group Partnership
- Leeds Local Medical Committee (LMC)
- Leeds Community Healthcare
- Leeds Teaching Hospital Trust
- Community Pharmacy West Yorkshire
- Local Professional Network (LPN) for Pharmacy
- Community Pharmacy North Yorkshire
- Community Pharmacy Humber
- Healthwatch Leeds
- Leeds prescribing GPs

All pharmacies, other stakeholders, all Leeds City Council Elected Members and dispensing GP practices in the Leeds Health and Wellbeing area received a letter notifying them of the consultation.

Comments were received from Community Pharmacy West Yorkshire, Leeds Community Healthcare NHS Trust, NHS England, North Yorks County Council and two community pharmacies. These are tabled at **Appendix 27**.

5.8 Stage four: final publication

The HWB will publish the PNA prior to 1 April 2018 in line with the regulations. The PNA will then be placed on the Leeds Observatory website.

5.9 Lifespan and review of the PNA

The PNA will be valid for three years from 1 April 2018 to 31 March 2021 when an updated version will be published. A review statement may be published before then if significant change occurs.

6. Mapping of current pharmacy provision

The PNA has identified and mapped current provision of pharmaceutical services in order to assess the levels and appropriateness of the provision.

6.1 Community pharmacies

There are 180 pharmacies currently operating in Leeds. At the time of the 2015 PNA, there were also two Essential Small Pharmacy Local Services (ESPLPS). All ESPLPS contracts ceased on 31 March 2015 and the Leeds pharmacies operating

under these contracts were transferred to a Local Pharmaceutical Service (LPS) contract. ESPLPS no longer exist.

There is now only one such LPS pharmacy commissioned by NHS England operating in Leeds which is situated in Pool-in-Wharfedale

This pharmacy is shown at **Appendix 1** and other maps throughout the appendices.

The LPS contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

6.2 Dispensing GP practices (controlled areas)

Dispensing doctors are medical practitioners authorised to provide drugs and appliances in designated rural areas known as 'controlled areas'.

There are seven dispensing GP practices, all of which are situated in the Outer North East area:

- The Harewood site only, at the Wetherby and Harewood Surgery
- Church View Collingham and the Thorner branch surgery
- Bramham Medical Centre
- The Scholes site only at Manston Surgery
- The Barwick-in-Elmet and Aberford sites of Garforth Medical Centre

The main sites do not dispense because there is sufficient pharmacy provision available locally.

The Leeds West area does not have any dispensing practices.

These seven dispensing practices are mapped at **Appendix 15**.

6.3 Dispensing appliance contractors (DACs)

There are currently no NHS England contracted appliance contractors based in Leeds. There are four outside Leeds, which may be used by Leeds community pharmacies. However the use of DACs is unlikely to be geographically bound and patients may be using DACs from across the country.

6.4 Distance-selling pharmacies

A distance-selling pharmacy is a registered pharmacy that provides services over the internet. There are seven distance-selling pharmacies in Leeds, five more than in 2015.

Table 10 Distance-selling pharmacies in Leeds

Pharmacy	Trading name	Postcode
PHARMACY2U LTD		LS14 2AL
Pharma Corner Ltd	Pharmacy Corner	LS8 4JL
Nightingale Yorkshire Ltd	Nightingale Pharmacy	LS11 5NX
Mission Start Ltd	Living Care Pharmacy Deliveries	LS11 5JJ
HealthNet Homecare Ltd	HealthNet Homecare Limited	LS12 6LS
GreenPharma Ltd	Chemist 247	LS11 7HL
Future Practice Ltd	Advantage Pharmacy	LS11 5SS

Patients can access pharmaceutical services from any community pharmacy, including mail order/internet pharmacies of their choice. This option increases accessibility as patients can access locally or nationally based internet pharmacies. Distance-selling pharmacies do not offer face-to-face essential services, but may offer other face to face services.

Leeds Outer North East area has seven dispensing GP practices and taken together with the seven distance-selling pharmacies across Leeds and community pharmacies that can be accessed in neighbouring inner areas, this does not constitute a gap in pharmaceutical services in the area.

There are 31,424 people who live in Lower Super Output Areas (LSOAs) where the centre of the LSOA is outside the one-mile buffer zone. This means that they will not have access to a pharmacy within one mile of their home. Some of these residents live within the Outer Community Committee areas but most have proximity to good road networks so are likely to be able to access a pharmacy within 20 minutes by car or public transport.

There is therefore adequate provision and no geographical gaps for the needs of the population in the area of the Health and Wellbeing Board.

The location of all community pharmacies, dispensing GP practices and distance selling pharmacies in Leeds is included at **Appendix 1**.

6.5 Opening times

Table 11 Pharmacy opening times (October 2017)

Opening times	Number of pharmacies open
Before 8 am	22
After 6 pm	83
After 8 pm	31
After 10 pm	23
Saturday	126
Saturday afternoon	111
Sunday	41

In terms of out of hours access for Leeds citizens, 22 pharmacies are open before 8am, 83 after 6pm and 31 after 8pm. 23 are open after 10pm. A total of 126 of community pharmacies that responded to the PNA survey are open on Saturday. Of these, 111 are also open in the afternoon; 15 are open on a Saturday morning only and 41 community pharmacies are open on a Sunday. This means that overall, there is adequate provision for citizens to have a choice of pharmacies should they need to access out of hours.

The vast majority of heavily populated neighbourhoods in the Inner areas of Leeds have excellent access to a choice of local community pharmacies which are open for extended hours. The Outer Community Committee areas have fewer community pharmacies and fewer with extended opening hours.

Therefore, depending on where they live, some citizens may need to travel, either into one of the Leeds Inner areas, or to a pharmacy in an adjoining Health and Wellbeing area, should they require a service before 8am on a weekday, or on a Sunday. There is adequate provision within the Outer North East area on a Saturday and after 6pm, though none are open after 8pm.

This information is mapped at **Appendix 16 to 19**.

27 pharmacies are contracted by NHS England to open for a minimum 100 hours, an increase from 21 in 2015. This information is mapped at **Appendix 20**.

22 of the pharmacies which responded to the survey confirmed that they are working to a minimum of 100 hours. There are also now seven distance-selling pharmacies, an increase on the two reported in 2015. Infrastructure to aid access to pharmaceutical services has therefore improved over the last three years.

7 Commissioned services

Commissioners from Leeds City Council, NHS England and Leeds CCG Partnership were asked to provide details of all the services they commission in pharmacies. This information was mapped and analysed in stage two.

7.1 Local services commissioned by Leeds City Council

Community pharmacies can make a significant contribution to improving the public's health and are often a point of contact for people, including vulnerable people, who may not otherwise access health services.

Pharmacies can offer a number of services, commissioned or non-commissioned. This can range from signposting to offering more tailored services such as emergency contraception, blood pressure monitoring or diabetes support. Leeds City Council commissions community pharmacies to deliver a number of services which contribute towards the wellbeing of the Leeds population and delivery of the Leeds Health and Wellbeing Strategy.

7.1.1 Supervised consumption

Community pharmacists are commissioned to observe consumption of prescribed substitute medication for opiates to patients where supervision has been requested by the prescriber. The primary function of the service is to stabilise, reduce, and eventually replace, illicit opiate use and in so doing reduce harm and improve the health and psychological wellbeing of the patient. The aims of the service are to:

- offer a professional, user-friendly, non-judgemental, client-centred and confidential service
- ensure the safe and consistent consumption by patients of prescribed substitute medications for opiates
- minimise the misdirection of controlled drugs, thus contributing to a reduction in drug-related deaths in the community
- support patients in adhering to treatment programmes that will enable them to reduce the harm caused by illegal drug use
- monitor and offer advice to the patient on their general health and wellbeing
- promote access and make referrals to other primary care agencies where appropriate.

There are currently 163 community pharmacies in Leeds contracted to deliver this service and 133 of those returning questionnaires confirmed that they were providing this service. There is less provision in the Outer North East but depending on their postcode, it may be nearer for service users to travel to one of the pharmacies in an adjoining Community Committee area.

Appendix 21 shows the locations of the pharmacies that currently deliver the service.

The current contract for this service expires on 31 March 2018. A commissioning review was taking place during 2017, with new contracts to commence from 1 April 2018.

The review is looking at the whole process of opiate substitution treatment, from a service user first seeking support to address their drug use, through the period when

their medication is under supervision, to the point where they can take their medication unsupervised and ultimately become drug-free.

Leeds City Council is working closely with the commissioned drug and alcohol treatment provider in Leeds to monitor current need and estimate future levels of need for the service. Drug treatment services need to have city-wide coverage and be available in locations and at times which are convenient for service users.

All pharmacies within Leeds will be given the opportunity to demonstrate that they meet the requirements to deliver a supervised consumption service, as set out in the specification, and there will be no upper limit on the number of pharmacies that can be awarded a contract. Therefore there should be no gaps in this service over the life of the PNA.

7.1.2 Needle exchange

Community pharmacies are also commissioned to provide a convenient and flexible drop-in needle exchange service, offering free access to sterile needles, syringes and related materials. The aims of the service are to:

- Assist service users to remain healthy until they are ready, willing and able to address their injecting behaviour and ultimately achieve a drug-free life with appropriate support.
- Protect health and reduce the rate of blood-borne infections and drug-related deaths among service users by:
 - reducing the rate of sharing and other high-risk injecting behaviours
 - providing sterile injecting equipment and paraphernalia
 - promoting safer injecting practices
 - providing and reinforcing harm reduction messages including safe sex advice and advice on overdose prevention (e.g. risks of poly-drug use and alcohol use)
 - improving the health and safety of local communities by ensuring the safe disposal of used injecting equipment
 - encouraging and supporting service users to access local drug and alcohol services and other health and social care professionals where appropriate.⁷

The community pharmacy needle exchange service in Leeds was reviewed during 2015/16 in order to ensure that the service was being provided in the most appropriate geographical areas and that service users were receiving useful advice and support.

The review determined the areas in which the needle exchange provision is most needed. During January 2016, pharmacies which operate within the identified areas were invited to apply to provide the service. As a result, 15 pharmacies across Leeds were awarded contracts which are effective from 1 April 2016 until 31 March 2021.

Provision for this service is currently adequate, although regular monitoring is required to make sure that the locations and opening times of the pharmacies involved in the service continue to meet service user needs. **Appendix 22** shows the location of the pharmacies that deliver the service.

7.1.3 Lifestyle support

Data from the Health Survey for England (2016) highlight that

- two in 10 adults are smokers
- seven in 10 men and six in 10 women are overweight or obese
- one in three people have drinking habits that could be harmful
- half of women and one-third of men do not get enough exercise
- a quarter of the population engages in three or four unhealthy behaviours.

Forty per cent of the UK's disability adjusted life years lost are attributable to five risk factors: tobacco, hypertension, alcohol, being overweight or being physically inactive.

7.1.4 Smoking cessation

There has been significant progress made with respect to reducing smoking prevalence; this has been achieved through a comprehensive approach to tobacco control. However, despite significant reductions, smoking remains a high priority for Leeds and across the UK because it is still the major cause of premature morbidity and mortality, health inequalities and poor quality of life.

In Leeds, smoking prevalence is 17.8%, over 2% higher than the England average of 15.5%. This has improved from 22.7% in 2012 and is a reflection of the city's overall tobacco control activities and national policies. However smoking rates are significantly higher in several wards across Leeds, particularly in deprived areas, and amongst particular groups. These include routine and manual workers, with a smoking prevalence of 28.4%, members of some BME communities (particularly men), and people from lower socioeconomic groups.

In addition to the health impact that smoking has on our society, it is also a financial burden. It is estimated that in 2014/15, smokers in Leeds paid approximately £124m in duty on tobacco products; however, smoking costs the Leeds economy roughly twice the amount of duty raised at £224.8m.

7.1.5 Stop-smoking support

Stop-smoking services across the country are experiencing a decline in smokers accessing these services. The number of people setting a quit date through NHS Stop Smoking Services in 2016/17 fell for the fifth consecutive year to 307,507. This represents a decrease of 19.6% on 2015/16. However, the quality of interventions remains high, with a 51% success rate. There may be many reasons for the reduction in smokers accessing stop-smoking services, including the rise in smokers

switching to e-cigarettes and quitting. Stop-smoking services remain the most effective in helping smokers quit.

Following a comprehensive service review in 2015, a health needs assessment and stakeholder consultation, the stand-alone stop-smoking support service ceased in primary care and pharmacies in October 2017. The value of this contract was £4,000.

Despite this development, pharmacies remain an important setting in which to raise lifestyle issues and support customers to have a healthy lifestyle. Healthcare professionals can play an important role in supporting people to make small and sustainable changes that improve their health through making every contact count.

Brief and very brief interventions by healthcare professionals have also been shown to be effective ways of supporting sustainable behaviour change. Consumer research suggests that most people feel it is appropriate for healthcare professionals to ask about these behaviours and to offer help.

7.1.6 Maintaining a healthy weight

The latest Health Survey for England data (2016) shows that over a quarter of adults, and over 1 in 10 children aged 2 to 10 years, are obese, with the trend set to increase. Two Public Health Outcomes indicators are used to monitor the impact of overweight and obesity on the local population:

- the percentage of adults with excess weight
- the percentage of active and inactive adults.

In 2013/15, 62.3% of the Leeds population were overweight or obese; this is comparable with the England average. The Active People Survey is used to determine the percentage of active and inactive adults. In 2015, 28.9% of the adult Leeds population were inactive and 56.3% were active. These figures are also comparable with the England average.

Obesity can have a severe impact on people's health. Around 10% of all cancer deaths among non-smokers are related to obesity. The risk of coronary artery disease and type 2 diabetes directly increases with increasing levels of obesity and levels of type 2 diabetes are about 20 times greater for people who are very obese. These conditions shorten life expectancy.

Good eating and physical activity habits are key to maintaining a healthy body weight. These are impacted by significant external influences such as environmental and social factors. Changes in food production, the use and availability of motorised transport, and changing work/home lifestyle patterns, all contribute to the trend of increasing body weight.

There are currently no commissioned pharmacy weight management services in Leeds although pharmacists are encouraged to signpost to the One You Leeds service.

7.1.7 NHS Health Check

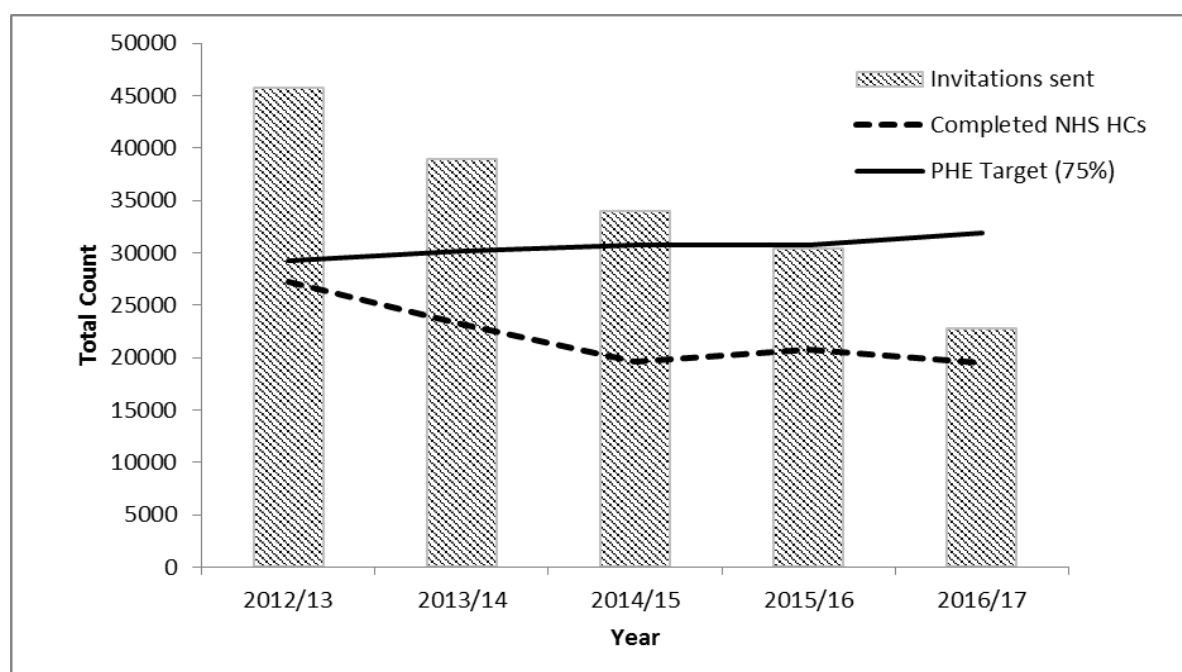
The NHS Health Check programme was introduced nationally by the Department of Health in 2009, following the publication of *Putting Prevention First: Vascular Checks and Risk Management* which set out plans for the NHS to introduce a systematic, integrated programme of vascular risk assessment and management. The aim of the NHS Health Check programme is to prevent cardiovascular disease (CVD), which includes heart disease, stroke, diabetes, kidney disease and certain types of dementia.

The programme is for people aged 40–74 who have not already been diagnosed with CVD. As part of a rolling programme, 20% of the eligible population are invited to have an NHS Health Check once every five years. Each NHS Health Check is delivered by a trained health professional who assesses the person for their risk of developing CVD in the future. Support and advice is then offered to help the person to reduce or manage their risk. The system allows referrals to treatment for those receiving abnormal results. Referrals to Healthy Living Services are also generated where appropriate.

The NHS Health Check programme has clear links to the outcomes set out in Section 4 of the Leeds Health and Wellbeing Strategy, in particular supporting people to live longer and healthier lives through behaviour change, early identification, prevention and management. The uptake of NHS Health Checks is one of the key indicators of the Best Council Plan (2015–2020).

According to data from Public Health England (2016/17), a total of 199,752 people in Leeds are eligible for an NHS Health Check. Leeds had an uptake of 73.2%; the average England uptake was 49.9%. However, data extracted locally via GP audit shows that the number of invitations sent to the eligible population has declined each year. As shown below, the number of completed NHS Health Checks has also plateaued in the last three years.

Figure 2 Leeds NHS Health Check performance (2012/13 – 2016/17)



Insight gained from Leeds residents in 2014 highlighted the need for a more flexible offer. As a result, a Health Check pilot project was commissioned to offer NHS Health Checks from four Asda pharmacies across the city. Over an 18-month period, a total of 78 people received an NHS Health Check through an Asda pharmacy. Despite low uptake, there were a number of positives including a strong working relationship between Public Health and Asda and staff willingness to deliver NHS Health Checks at a similar level of competence to primary care. Asda were able to refer into the Healthy Living Service and data could be extracted from the clinical system via Public Health to monitor outcomes.

A number of barriers were identified, including lack of participation from GPs, which impacted on the coverage of the programme. This then impacted on patient eligibility to take part in an NHS Health Check at the pharmacy and prevented wider marketing. The low number of completed NHS Health Checks meant staff skills were not maintained; further training was required, but proved difficult to arrange. Logistical issues were also experienced, such as lack of space and difficulty in tracking those people who were identified as high-risk back to primary care for follow up.

In 2015, a Citizens' Panel survey of 1,726 people was carried out to obtain views from the public on the NHS Health Checks in Leeds. Having appointments available at their GP surgery would encourage, or has encouraged, people to book an NHS Health Check. Having information on what happens during an NHS Health Check, and being sent reminders, were also important factors in their decision to book an NHS Health Check. The availability of appointments at a local pharmacy or other local community venues did not appear to be an incentive for booking an NHS Health Check, with just 153 out of 1,726 responses selecting this option.

Some people considered location to be an important factor in encouraging attendance and believed more flexibility is needed, particularly as a health check when feeling well is not always a priority, ahead of work and life commitments. However, there was a general lack of awareness of the NHS Health Check in terms of the intended target audience, who is responsible for the invitation and how often individuals can have a check.

The NHS Health Check service is currently being delivered citywide by 106 GP practices with the contract due to end in March 2018. A comprehensive review of the NHS Health Check programme has been completed to identify and assess reasons for the continued decline in invitation and uptake. A number of disengaged groups – particularly males, people from the 40–49 age category and people with learning difficulties or severe mental illness – were identified and Leeds City Council will use this insight to inform future activity.

Community pharmacies are not currently commissioned by Leeds City Council to provide NHS Health Checks, but coverage through GPs is adequate.

7.1.8 Leeds Blood Pressure Wise

Leeds Blood Pressure Wise was implemented in November 2017 following a collaborative funding application from Leeds City Council and the NHS Leeds Clinical Commissioning Group's Partnership to the British Heart Foundation.

The service will target 10,000 new blood pressure checks over a two-year period. The aim of the project is to increase the detection and management of hypertension and atrial fibrillation, whilst also acting as a gateway into NHS Health Checks and the One You Leeds service.

Of the 10,000 blood pressure checks, 2,400 will be delivered by trained pharmacy staff in six community pharmacies located within Deprived Leeds, such as Harehills, Bramley and Seacroft. The member of the pharmacy team nominated to become their trained blood pressure practitioner will receive training on how to measure blood pressure and lead better conversations around healthy living as well as receiving support with using the IT system.

The other 7,600 blood pressure checks will be targeted within the Leeds City Council workforce.

The service will target people aged 35 or above without pre-existing hypertension, atrial fibrillation or cardiovascular disease. Pregnant women and people who have had their blood pressure measured at their GP in the last 12 months are ineligible. Patients that enter the service will be required to consent to having their information shared with their GP via NHS spine. Patients that record an initial blood pressure of 140/90mmHg or higher will be offered the loan of a digital monitor to carry out a week's home blood pressure monitoring prior to a follow-up appointment with the practitioner in the commissioned pharmacy.

7.1.9 Sexual health and wellbeing

Sexual health is an important area of public health. A large proportion of the adult population of England is sexually active and access to good-quality sexual health services is known to improve the health and wellbeing of both individuals and populations. In Leeds there are strong links between deprivation and the incidence of sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest rates experienced by women, men who have sex with men (MSM), teenagers, young adults and BME groups.

The Public Health Sexual Health Team commission pharmacy-based services in Leeds which support the delivery of two main sexual health-related Public Health Outcomes Framework measures: under-18 conceptions and chlamydia diagnosis (15–24 year olds).

Across the city, 38 sites are commissioned to deliver the Enhanced Sexual Health Pharmacy Scheme (ESHPS). These sites have been selected based on their location within sexual health priority areas: areas where there are high levels of teenage conceptions and higher rates of multiple terminations and areas that are geographically more isolated from city centre services.

The ESHPS offers free access to emergency hormonal contraception (EHC), pregnancy testing and chlamydia screening. Participating sites which have a service level agreement with the local authority, have private consultation rooms and a toilet on site, operate core opening times for the scheme and have committed to declaring their competency and keeping training up to date. A Sexual Health Needs Assessment (SHNA) is currently underway with the aim of updating key sexual health data profiles and mapping the coverage of sexual health services around the city. This SHNA will be used to update sexual health priority areas and help assess whether services are located in areas of need.

The ESHPS is currently being reviewed in relation to the findings of the SHNA. This review will also provide sites currently not offering the scheme but based within areas of priority the opportunity to express their interest in running the scheme. The review also recognises the need to create better referral pathways between providers of EHC and contraceptive services in order to mitigate the risk of EHC being used as a primary form of contraception.

Although it is recognised that prices may change during the lifetime of this PNA, pharmacists are currently paid a £10 consultation fee when the ESHPS is accessed, an additional £3 when a pregnancy test is performed and £3 for a completed chlamydia screen (resources provided via the commissioner). Pharmacies are also reimbursed for the price of the drug provided (ulipristal acetate and levonorgestrel). From April 2018, Leeds Community Healthcare NHS Trust will take over the day-to-day management of the ESHPS as the contract provider of the Integrated Sexual Health Service in Leeds. This feature has been built into many Integrated Sexual Health services contracts nationally as it provides a closer relationship, clinical

governance overview and referral pathways between community pharmacy providers and clinical leads within the Sexual Health Service.

The current EHC pharmacies are mapped against population density of females aged 16+yrs at **Appendix 23** and against under-18 conceptions/unintended pregnancies at **Appendix 24**. They are sited in areas of highest teenage pregnancy and no gaps in services have been identified.

7.1.10 Medication Administration Record (MAR)

The Medication Administration Record (MAR) Chart scheme commissions community pharmacies to provide domiciliary patients (who receive assistance with their medicines from Leeds City Council Adult Social Care (ASC) or commissioned homecare providers) with an accurate Medication Administration Record (MAR) chart(s). This is a requirement at all times the pharmacy is open. The contract runs for 3 years from 1 April 2015 to 31 March 2018. This service does not cover anyone in care homes.

A map of the community pharmacists providing MAR is shown at **Appendix 25**.

7.2. NHS England-commissioned services

7.2.1 Health protection – national flu immunisation programme 2017/18

The aim of the national flu immunisation programme is to ensure high levels of flu immunisation, this being one of the most effective interventions we can make to reduce harm from flu and pressures on health and social care services during the winter. Those eligible should be encouraged to take up the offer of the free flu vaccination as early as possible between September and early November, before flu starts circulating in the community.

In 2017/18 the following people are eligible for flu vaccination:

- those aged 65 years and over
- those aged six months to under 65 in clinical risk groups (including morbidly obese people with a BMI of 40 or over)
- pregnant women (any trimester)
- all two and three-year-olds as part of the primary care programme
- four-year-olds and school-aged children in Years 1, 2, 3 and 4 as part of the schools-based programme (regardless of where educated or geography)
- those in long-stay residential and/or nursing care homes
- people in receipt of Carer's Allowance or who are the main carer of an elderly or disabled person (not paid/employed carers).

Health and social care workers who are in direct contact with patients or service users are shortly expected to be offered flu vaccination by their employer; this will include GP practice staff.

To improve access and choice with the aim of increasing uptake, NHS England commission the national community pharmacy advanced service, allowing them to offer and deliver flu vaccine to all eligible adult patients. In 2016/17 approximately 115 pharmacists in Leeds were signed up to deliver this service but this has increased to 134 in 2017/18.

Where pharmacies are not part of the national pharmacy flu service, NHS England suggest they should be actively promoting the flu vaccine through resources and advice and signposting the patient to their GP.

7.2 2 NHS Urgent Medicine Supply Advanced Service (NUMSAS)

In June 2017, NHS England commissioned the NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilot. This replaced the West Yorkshire Urgent Repeat Medicine Service, which had previously been commissioned by all three CCGs in Leeds. The purpose of the service is to facilitate appropriate access to repeat medication out of hours and relieve pressure on urgent care and emergency care services by enabling access to repeat medicines in emergency situations. The service aims to reduce the pressures and demands on unscheduled care such as A&E, out-of-hours GPs and NHS111.

The community pharmacists commissioned by NHS England to provide NUMSAS are shown at **Appendix 26**. Although the Outer North East and Outer North West are less well served, main road links are nearby to facilitate reasonably speedy access to the nearest available site.

7.2.3 Palliative care

Palliative care services enable the prompt supply of specialist palliative care medicines, the demand for which may be urgent and/or unpredictable. Pharmacy contractors commissioned to provide this service are required to stock a locally agreed range of palliative care medicines and make a commitment to ensure that users of this service have prompt access to these medicines at all times in the event that they are required.

The pharmacy also provides information and advice to the user, carer and clinician. They may also refer to specialist centres, support groups or other health and social care professionals where appropriate.

At present the number of pharmacies commissioned, and the terms of the service commissioned, vary across CCG areas and Leeds community pharmacies are not currently commissioned to provide this service. However, some pharmacies returning survey questionnaires said they were providing this service.

NHS England are currently reviewing the palliative care service to ensure a consistent approach across West Yorkshire whereby all contractors commissioned to provide this service will receive the same remuneration and work to the same formulary. The new service is expected to be in place from 1 April 2018.

7.3 Local services commissioned by Leeds CCGs

The three previously separate CCGs in Leeds now work together as a NHS Leeds Clinical Commissioning Group's Partnership. The following services are currently commissioned.

7.3.1 Pharmacy First

The NHS Leeds Clinical Commissioning Group's Partnership commission Pharmacy First from the majority of community pharmacies. The only exceptions are pharmacies that have significantly higher usage of the NHS England-commissioned Minor Ailments Scheme.

The Pharmacy First scheme provides the local population with rapid access to a pharmacist who can give advice, and where necessary supply medication from an official list, for a range of minor ailments. This releases capacity in general practice and provides an appropriate alternative to the use of general practice or other healthcare environment (i.e. A&E, out-of-hours urgent care). The service is aimed at patients who use GP or out-of-hours services when they have a minor ailment, rather than self-care or purchasing medicines over the counter. The service aims to change patient behaviours and to educate and assist patients in how to access self-care and the appropriate use of healthcare services.

7.3.2 Head lice

The head lice scheme is now incorporated into the Pharmacy First service. Pharmacies providing this service offer evidence-based advice and support to people on the management of head lice and medication for the treatment of head lice. The service is intended to help reduce the number of inappropriate referrals made to the Head Start clinic, as well as helping GPs make efficient use of their time so they can focus on more complex patients. The service allows patients access to treatment on the NHS without a prescription but children less than six months must be referred to their GP. This is due to the product licences of the available treatments.

8. Maps of commissioned services

The appendices following this assessment show the full range of pharmacy provision that is currently available in the Leeds Health and Wellbeing area.

9. Conclusions

- The PNA has found that Leeds has very good coverage of necessary pharmaceutical services with no gaps in provision. There are also no current gaps in the provision of other relevant services in the area of the Leeds Health and Wellbeing Board.

- The PNA has assessed likely changes in the population that could change the requirement for pharmaceutical services, the demographics of the city and current health and wellbeing levels in the area. It has not identified any current or future needs which cannot be met by current providers on the pharmaceutical list.
- The 181 pharmacies which were working within the national contract in Leeds in 2015 has reduced by one to 180 but there are now seven distance selling pharmacists, an increase of five since the last PNA.
- Satisfaction with access to pharmaceutical services is high. The majority of the PNA survey respondents live within one mile of a pharmacy and 80% of the residents in the PNA public survey self-reported that availability of pharmacies in their area was very good (42%) or good (38%).
- A very small minority of residents reported some difficulty accessing out-of-hours services, but most areas have a choice of pharmacies that are open on Saturday, Saturday afternoon, after 6 pm, after 8 pm, after 10 pm and on a Sunday. 95% of residents self-reported that they have a choice as to which pharmacy they can use.
- The Outer North East Community Committee area is less well served, with no pharmacy open after 8 pm, after 10 pm, or before 8 am. However, there are seven dispensing GPs in this area and seven distance selling pharmacies across Leeds. 23% of the community survey sample reported that they use other pharmacies as well as their local pharmacy so this does not represent a gap for the area.
- There are fewer community pharmacists in all of the Outer areas but 73% of Leeds residents responding to the PNA survey said they can reach a pharmacy in up to 10 minutes; 87% of residents have access to public transport to within walking distance of the pharmacy and 71% of pharmacies report a bus or other public transport stop less than two minutes (walking at a moderate pace) from the pharmacy.
- A small minority of residents who responded to the survey (3.2%) take between 21–30 minutes, and 1% just over 30 minutes, to reach a pharmacy.
- Satisfaction with the quality of pharmacies is also high. Just over three-quarters (76%) of residents responding to the PNA survey said that the quality of pharmacies in their area was good or very good and 95% of residents reported that they are happy with the services that their local or usual pharmacy provides.
- Some of the newly-emerging communities may not be using the available services as much as they might because of potential language and cultural barriers, but this can be adequately addressed by current providers.

- The full capacity of community pharmacy as described in the Community Pharmacy Forward View (2016) does not yet seem to have been fully utilised in Leeds. However future capacity is building and there are now 149 Healthy Living Pharmacies in Leeds. This provides an excellent base on which community pharmacies can integrate into New Models of Care, build aspirations for the neighbourhood health and wellbeing hubs and reduce health inequalities

9.1 Recommendations

- That the Health and Wellbeing Board is satisfied that the population of Leeds currently has very good access to pharmaceutical services and there are no current gaps in the provision of necessary services to meet the needs of the Leeds Health and Wellbeing Board area population.
- That the Health and Wellbeing Board is satisfied that there are no current gaps in the provision of other relevant services to meet the needs of the Leeds Health and Wellbeing Board area population.
- That the PNA has not identified any future needs which could not be met by pharmacies already on the pharmaceutical list, which would form part of related commissioning intentions.
- That the Health and Wellbeing Board is satisfied that there is a reasonable and adequate choice of pharmacies and pharmaceutical services in all areas of Leeds.
- That the Health and Wellbeing Board is aware that New Models of Care will further change the local health landscape, including re-assessing the role and potential of the community pharmacy team. There is capacity for this enhanced role to be done through the existing contracts and will provide greater opportunities for them to fully support the public's health and wellbeing.
- That pharmacies continue to develop, exercise and extend where appropriate their expertise around equality and diversity to ensure they continue to respond fully to meeting the needs of a changing and increasingly diverse population.

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Appendix 25	Map to show pharmacists commissioned to provide Medication Administration Record (MAR).
Appendix 26	Map to show pharmacists commissioned by NHS England to provide NHS Urgent Medicine Supply Advanced Service (NUMSAS).
Appendix 27	60 day consultation feedback table

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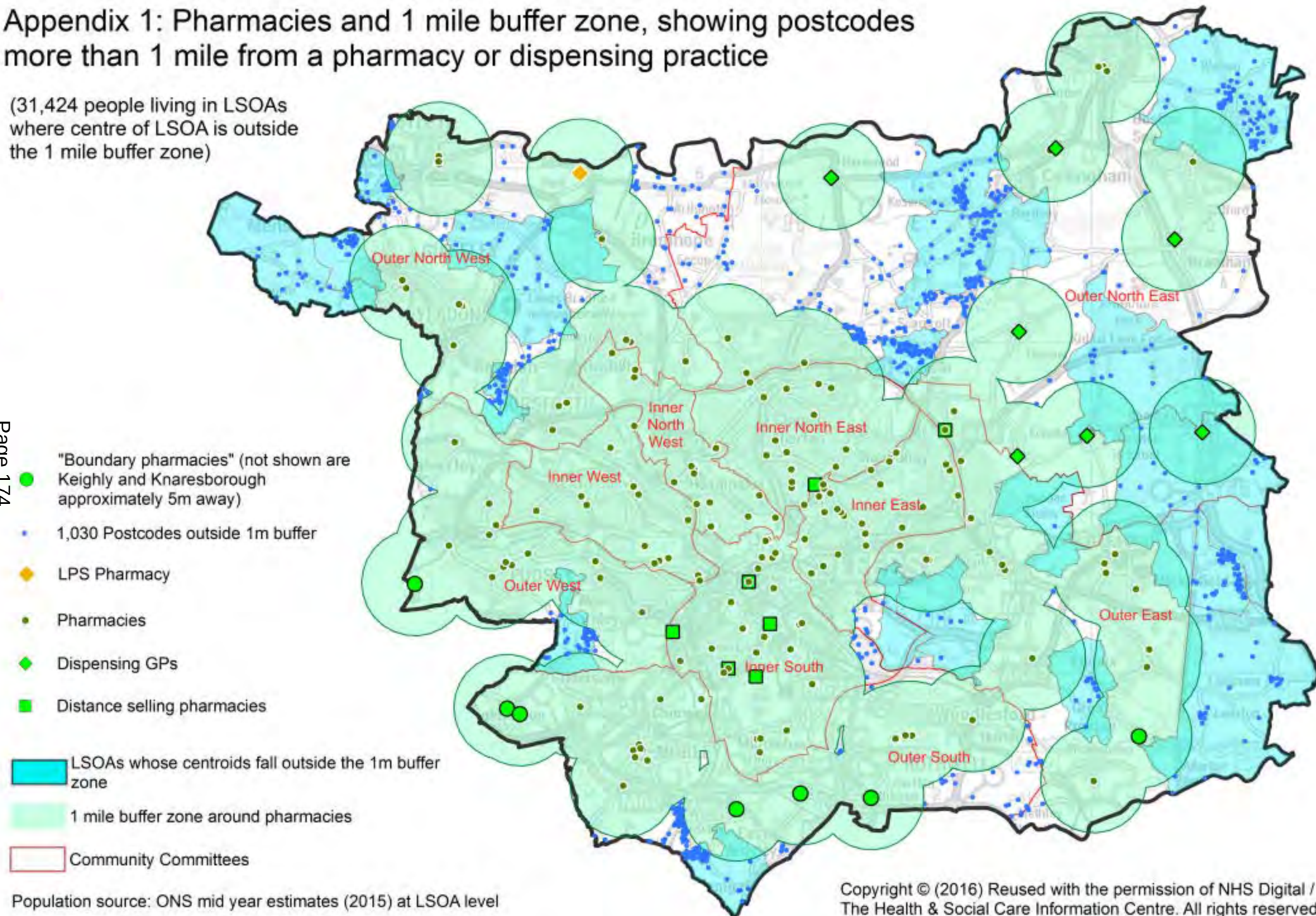
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Appendix 1: Pharmacies and 1 mile buffer zone, showing postcodes more than 1 mile from a pharmacy or dispensing practice

(31,424 people living in LSOAs where centre of LSOA is outside the 1 mile buffer zone)

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Appendix 2: Area overview profile for Inner East Community Committee

This profile presents a high level summary of data sets for the Inner East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	6,273	39%	67%
Pakistani	2,124	13%	6%
Black - African	1,832	11%	5%
Any other white background	1,153	7%	4%
Bangladeshi	691	4%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	9,382	60%	81%
Urdu	979	6%	3%
Bengali	491	3%	1%
Czech	428	3%	1%
Polish	337	2%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

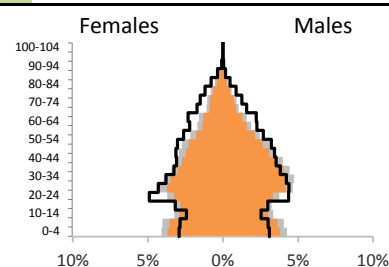
Population: 89,506

43,035

46,471

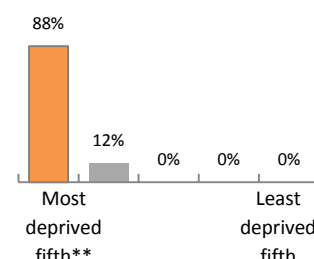
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

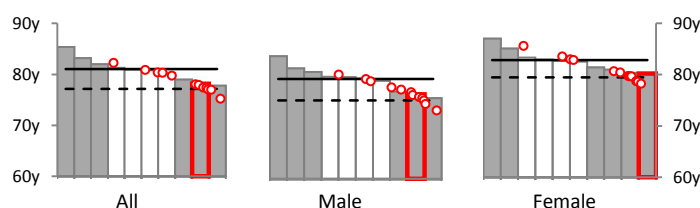


GP recorded ethnicity, top 5	% Area	% Leeds
White British	52%	71%
Other White Background	11%	10%
Pakistani or British Pakistani	9%	3%
Black African	8%	3%
Other Ethnic Background	4%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

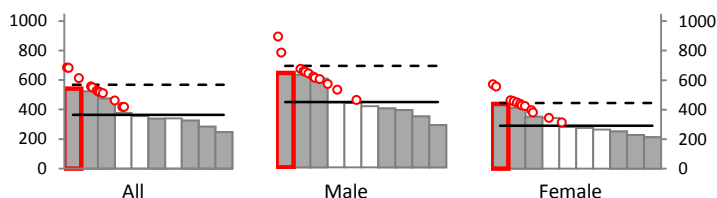
ONS and GP registered populations



(years)	All	Males	Females
Inner East CC	78.1	76.2	80.2
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

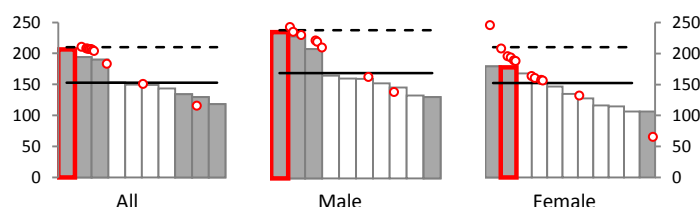
Slope index of inequality (see commentary) = 2.1

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner East CC	541	640	437
Highest MSOAs in area	683	884	569
Lowest MSOAs in area	415	454	311
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

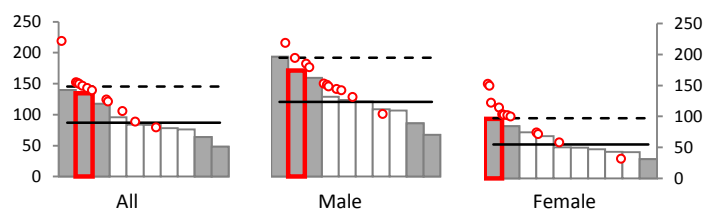


(DSR per 100,000)	All	Males	Females
Inner East CC	207	236	178
Highest MSOAs in area	270	307	245
Lowest MSOAs in area	116	139	65
Leeds resident	153	170	137
Deprived fifth	210	239	182

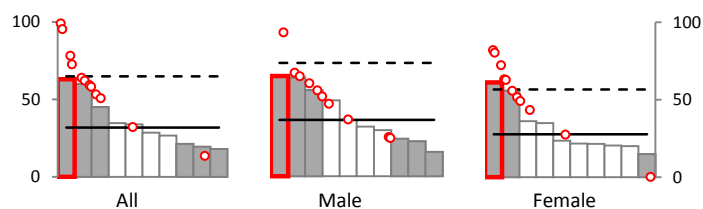
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



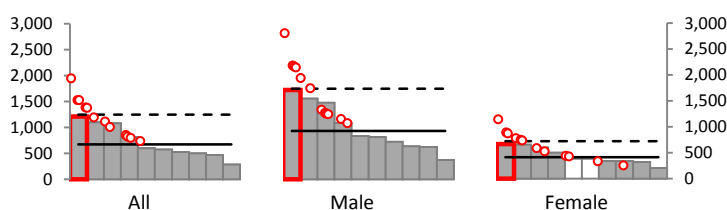
(DSR per 100,000)	All	Males	Females
Inner East CC	135	171	96
Highest MSOAs in area	219	306	152
Lowest MSOAs in area	79	101	31
Leeds resident	87	121	55
Deprived fifth**	145	192	97

Respiratory disease mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Inner East CC	63	65	61
Highest MSOAs in area	99	116	138
Lowest MSOAs in area	13	25	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

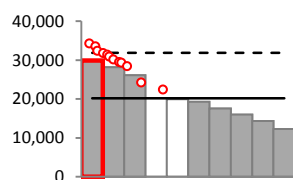
HES



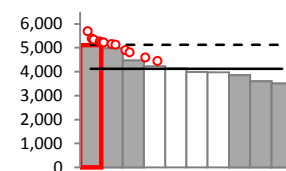
(DSR per 100,000)	All	Males	Females
Inner East AC	1,211	1,724	663
Highest MSOAs in area	1,940	2,811	1,138
Lowest MSOAs in area	735	1,079	249
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

GP recorded conditions, persons, October 2015 (DSR per 100,000)

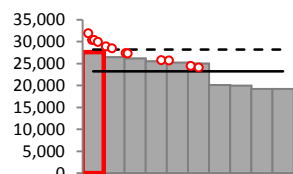
GP data

**Smoking (16y+)**

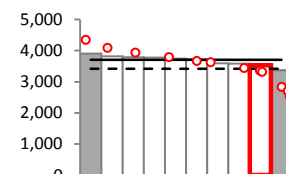
Inner E CC	29,919
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

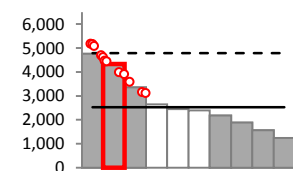
Inner E CC	5,113
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

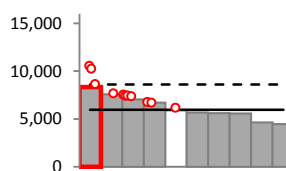
Inner E CC	27,592
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Inner E CC	3,532
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

Inner E CC	4,330
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Inner E CC	8,327
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Inner East Community Committee

The health and wellbeing of the Inner East Community Committee contains some variation across the range of Leeds, tending strongly towards ill health. Around 9 in 10 people live in the most deprived fifth of Leeds*. Life expectancy within the 12 MSOA** areas making up the Community Committee are generally among the shortest in Leeds and mostly significantly lower than Leeds (with some notable exceptions). However, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 2.1 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy for the Community Committee is significantly lower than Leeds for overall.

The age structure bears a close resemblance to that of Leeds overall but with larger proportions of children. GP recorded ethnicity shows the Community Committee to have smaller proportions of “White background” than Leeds and higher proportions of some BME groups. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture with BME groups more predominant than in Leeds.

All-cause mortality for under 75s is significantly above the Leeds average for men, women and overall – it is the highest for any Community Committee in Leeds. Most MSOAs are significantly above Leeds, and the *Cross Green, East End Park and Richmond Hill* MSOA has the second highest all-cause mortality rate overall in the city. The *Lincoln Green and Ebor Gardens* MSOA has the highest mortality rate in the city for men. For women, the MSOA with highest mortality rate is *Cross Green, East End Park and Richmond Hill* and this is the second highest in Leeds.

Cancer and circulatory disease mortality rates are quite widely spread at MSOA level but the overall Community Committee rates are significantly higher than Leeds. The Community Committee has the highest rates of respiratory disease mortality in the city, the *Cross Green, East End Park and Richmond Hill* MSOA has an overall respiratory disease mortality rate that is 3rd highest in the city overall, and also 2nd highest in the city for females.

Alcohol specific admissions for this Community Committee are the highest in Leeds, and almost all the MSOAs in the area have overall and male rates significantly above the Leeds rates. Smoking in the MSOAs is all significantly above the Leeds average, with the highest Community Committee rate in Leeds. Obesity rates in all the MSOAs are significantly above Leeds, the Community Committee again is the highest in the city. COPD and CHD show all MSOAs as being significantly above Leeds. Diabetes rates are also all significantly above Leeds average, with the Community Committee again coming top. Cancer at Community Committee level is nearly significantly below the city, and two MSOAs are within the lowest three in Leeds (*Harehills* | *Harehills Triangle*), this is expected as deprived areas often have low GP recorded cancer due to non/late presentation.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 3: Area overview profile for Inner North East Community Committee

This profile presents a high level summary of data sets for the Inner North East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	4,290	40%	67%
Pakistani	1,690	16%	6%
Indian	648	6%	2%
Black - African	537	5%	5%
Any other white background	508	5%	4%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	7,580	73%	81%
Urdu	674	6%	3%
Panjabi	315	3%	1%
Bengali	172	2%	1%
Polish	135	1%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

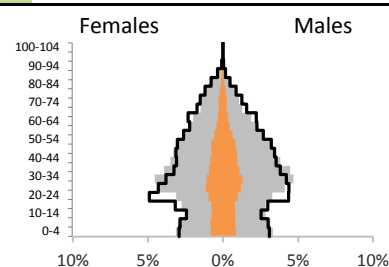
Population: 80,349

40,180

40,169

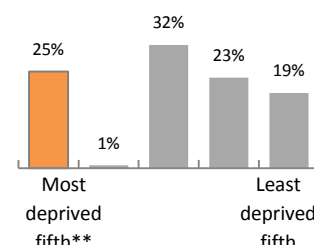
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.



GP recorded ethnicity, top 5	% Area	% Leeds
White British	52%	71%
Other White Background	13%	10%
Pakistani or British Pakistani	8%	3%
Indian or British Indian	6%	3%
Black African	3%	3%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

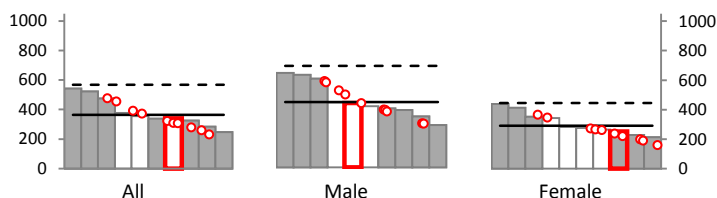
ONS and GP registered populations



(years)	All	Males	Females
Inner North East CC	80.9	79.3	82.5
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

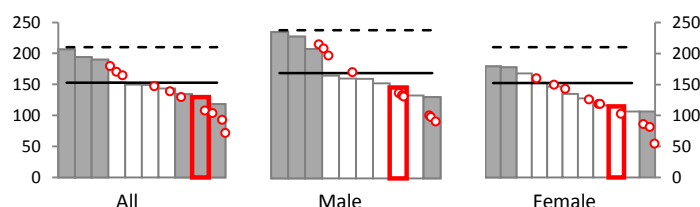
Slope index of inequality (see commentary) = 4.2

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner North East CC	340	436	252
Highest MSOAs in area	474	582	364
Lowest MSOAs in area	227	294	157
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

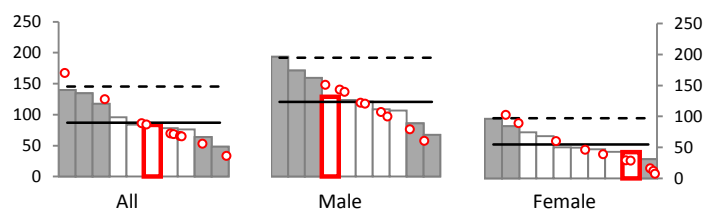
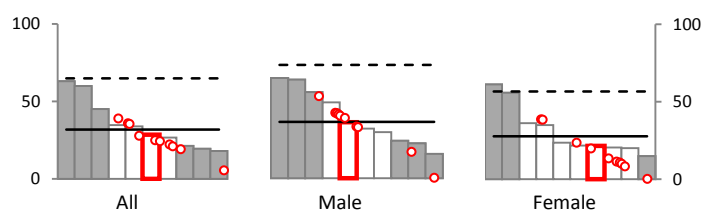


(DSR per 100,000)	All	Males	Females
Inner North East CC	130	147	115
Highest MSOAs in area	179	216	160
Lowest MSOAs in area	71	92	54
Leeds resident	153	170	137
Deprived fifth	210	239	182

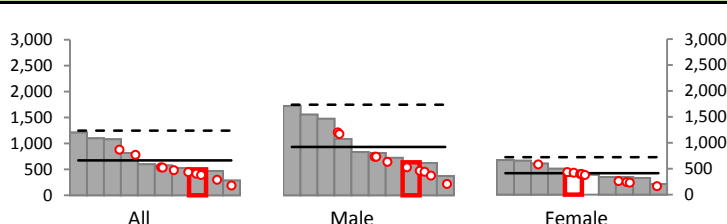
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

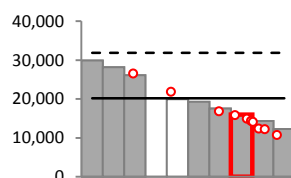
ONS and GP registered populations

**Respiratory disease mortality - under 75s, 2010-14 ranked****Alcohol specific admissions, 2012-14 ranked**

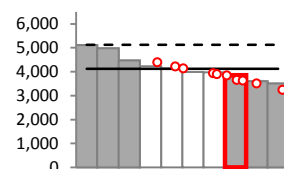
HES

**GP recorded conditions, persons, October 2015 (DSR per 100,000)**

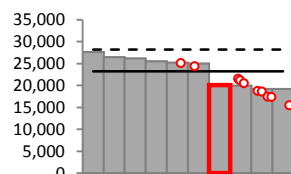
GP data

**Smoking (16y+)**

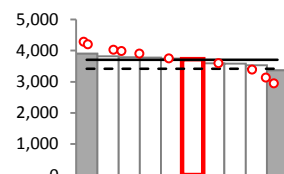
Inner NE CC	15,994
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

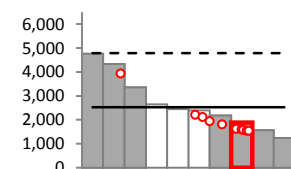
Inner NE CC	3,856
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

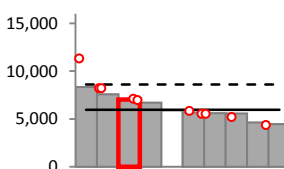
Inner NE CC	20,065
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Inner NE CC	3,724
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

Inner NE CC	1,888
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Inner NE CC	7,033
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Inner North East Community Committee

The health and wellbeing of the Inner North East Community Committee contains some variation across the range of Leeds, overall in the midrange of Leeds. Around 25% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 10 MSOA** areas making up the Community Committee are generally average for Leeds. However, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 4.2 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy for the Community Committee is more or less the same as for Leeds overall.

The age structure bears a close resemblance to that of Leeds overall except for lower numbers of young adults. GP recorded ethnicity shows the Community Committee to have smaller proportions of "White background" than Leeds and higher proportions of some BME groups, especially "Pakistani or British Pakistani". However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is not significantly different to the Leeds average, none of the MSOAs have extremely high values. Cancer and circulatory disease mortality rates are widely spread over Leeds at MSOA level but the Community Committee rates are not significantly different to Leeds – except for cancer mortality overall which is. The *Chapeltown* MSOA male circulatory mortality is fifth highest in Leeds.

Alcohol specific admissions for this Community Committee are significantly below Leeds for men and overall. Almost all the MSOAs in the area have rates significantly below the Leeds rates. Smoking in the MSOAs is all below the Leeds average, except for *Chapeltown* and *Meanwood "6 Estates"* which are actually significantly above Leeds. GP recorded obesity shows the same situation, with *Chapeltown* and *Meanwood "6 Estates"* MSOAs again being above the Leeds average. All MSOAs have CHD rates around average or significantly below those of Leeds.

GP recorded cancer overall is not significantly different to the city, but the *Roundhay* MSOA has the 4th highest rate of recorded cancer in Leeds. Diabetes at MSOA level includes 5 areas above Leeds, the highest of which is *Chapeltown* in second place in the city.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 4: Area overview profile for Outer North East Community Committee

This profile presents a high level summary of data sets for the Outer North East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	5,080	73%	67%
Indian	367	5%	2%
Pakistani	261	4%	6%
Any other white background	242	3%	4%
Any other Asian background	132	2%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	6,047	90%	81%
Urdu	83	1%	3%
Panjabi	73	1%	1%
Arabic	49	1%	1%
Polish	43	1%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

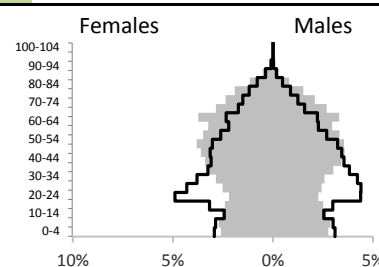
Population: 63,343

32,552

30,791

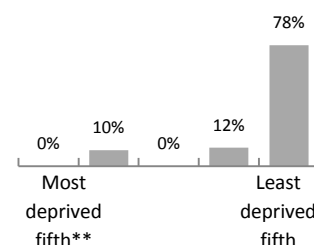
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

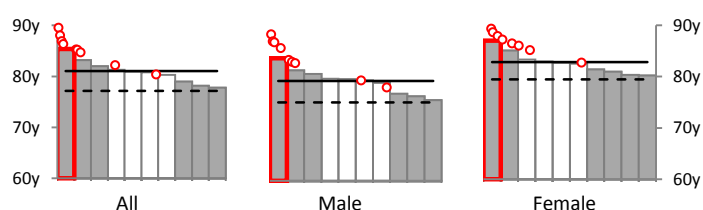


GP recorded ethnicity, top 5	% Area	% Leeds
White British	83%	71%
Other White Background	5%	10%
Indian or British Indian	4%	3%
Pakistani or British Pakistani	2%	3%
Other Ethnic Background	1%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

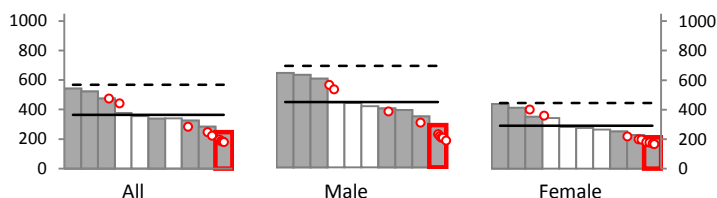
ONS and GP registered populations



(years)	All	Males	Females
Outer North East CC	85.4	83.5	87.0
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

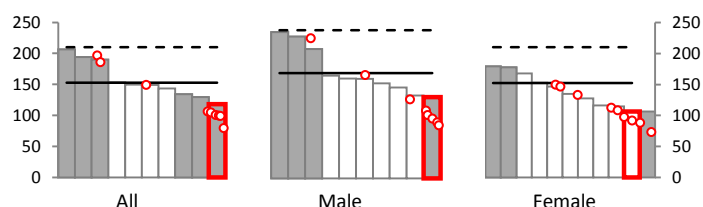
Slope index of inequality (see commentary) = 6.6

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer North East CC	247	285	213
Highest MSOAs in area	472	556	397
Lowest MSOAs in area	176	178	164
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked



(DSR per 100,000)	All	Males	Females
Outer North East CC	118	131	106
Highest MSOAs in area	196	253	149
Lowest MSOAs in area	79	85	72
Leeds resident	153	170	137
Deprived fifth	210	239	182

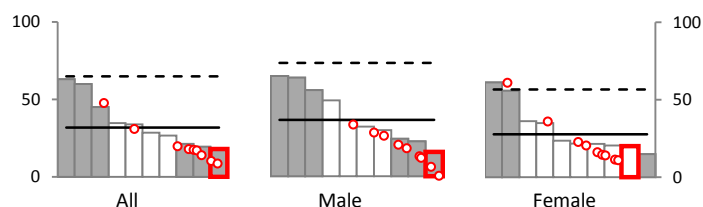
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



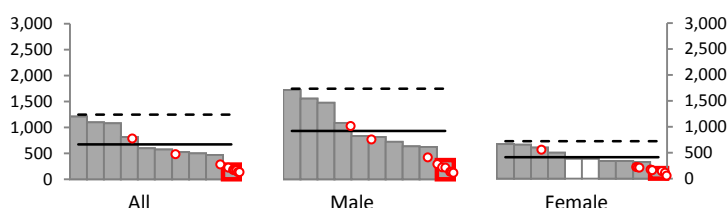
(DSR per 100,000)	All	Males	Females
Outer North East CC	48	67	31
Highest MSOAs in area	91	144	42
Lowest MSOAs in area	30	34	14
Leeds resident	87	121	55
Deprived fifth**	145	192	97

Respiratory disease mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Outer North East CC	18	16	20
Highest MSOAs in area	47	33	61
Lowest MSOAs in area	8	0	11
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

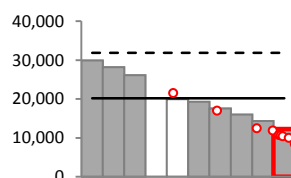
HES



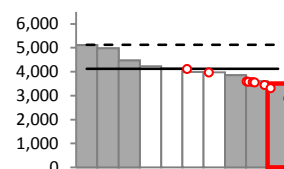
(DSR per 100,000)	All	Males	Females
Outer North East AC	284	373	203
Highest MSOAs in area	783	1,022	551
Lowest MSOAs in area	131	120	49
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

GP recorded conditions, persons, October 2015 (DSR per 100,000)

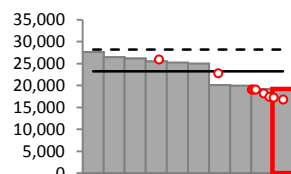
GP data

**Smoking (16y+)**

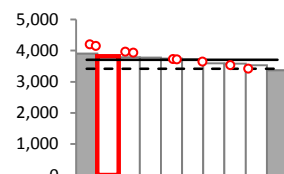
Outer NE CC	12,261
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

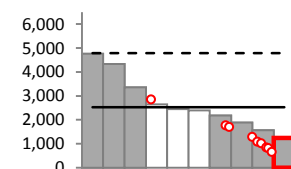
Outer NE CC	3,507
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

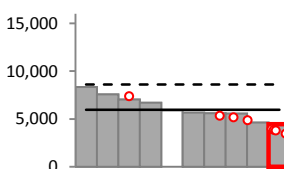
Outer NE CC	19,180
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Outer NE CC	3,821
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

Outer NE CC	1,246
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Outer NE CC	4,441
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Outer North East Community Committee

The health and wellbeing of the Outer North East Community Committee contains very wide variation across the full range of Leeds, overall looking very healthy within the city. None of the population live in the most deprived fifth of Leeds*. Life expectancy within the 9 MSOA** areas making up the Community Committee are mainly among the longest in Leeds but do include a reasonably wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 6.6 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and the highest in Leeds overall.

The age structure bears very little resemblance to that of Leeds overall with many fewer young adults and greater proportions of those aged over 40. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is well below the Leeds average for men and women, as well as overall for the Community Committee – the lowest rates in the city. Only two MSOAs are above Leeds the rate in every case - *Wetherby East, Thorp Arch and Moor Allerton*.

Cancer, circulatory, and respiratory disease mortality rates are widely spread but in the main are at the very low end, the Community Committee rates are therefore very low. The same two MSOAs feature as the highest two in the Community Committee in each case here.

Alcohol specific admissions are concentrated at the very low end except for the *Moor Allerton* MSOA which is higher than Leeds rates for males, females, and overall. GP recorded smoking, obesity, CHD, COPD and diabetes rates are the lowest of all Community Committees with the same *Moor Allerton* MSOA being the highest in each case.

GP recorded cancer for the Community Committee is almost the highest in Leeds reflecting the low numbers in more deprived areas who are thought to present with symptoms late.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 5: Area overview profile for Inner West Community Committee

This profile presents a high level summary of data sets for the Inner West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	6,820	68%	67%
Any other white background	604	6%	4%
Pakistani	522	5%	6%
Black - African	424	4%	5%
Any other ethnic group	214	2%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	7,833	80%	81%
Polish	265	3%	1%
Urdu	251	3%	3%
Other than English	220	2%	1%
Believed to be Other than English	161	2%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

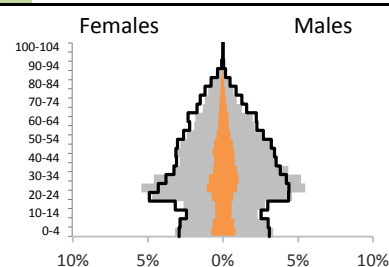
Population: 75,838

36,996

38,842

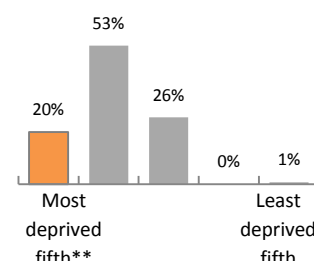
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

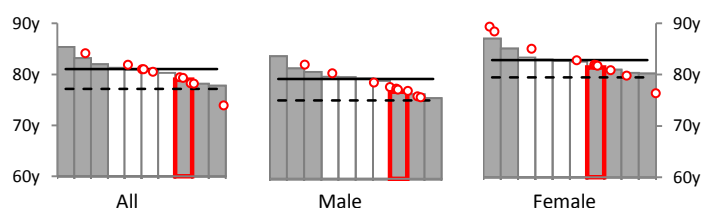


GP recorded ethnicity, top 5	% Area	% Leeds
White British	76%	71%
Other White Background	10%	10%
Black African	2%	3%
Pakistani or British Pakistani	2%	3%
Other Ethnic Background	2%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

ONS and GP registered populations

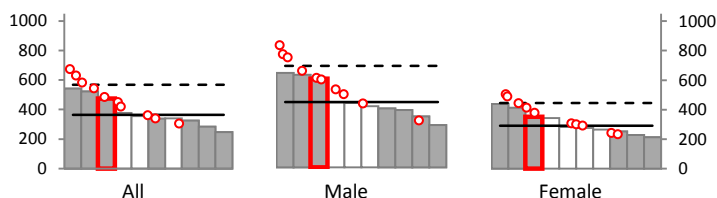


(years)

	All	Males	Females
Inner West CC	79.0	76.7	81.4
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

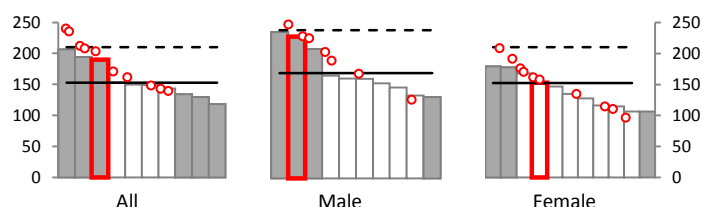
Slope index of inequality (see commentary) = 6.2

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner West CC	475	599	351
Highest MSOAs in area	671	825	503
Lowest MSOAs in area	302	314	232
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

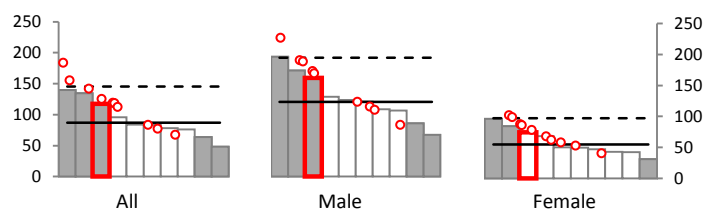


(DSR per 100,000)	All	Males	Females
Inner West CC	190	229	153
Highest MSOAs in area	240	292	208
Lowest MSOAs in area	139	127	96
Leeds resident	153	170	137
Deprived fifth	210	239	182

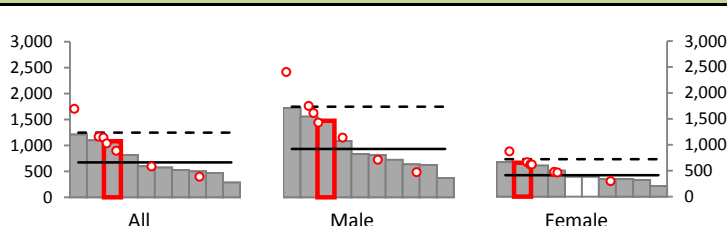
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

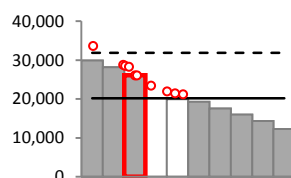
ONS and GP registered populations

**Respiratory disease mortality - under 75s, 2010-14 ranked****Alcohol specific admissions, 2012-14 ranked**

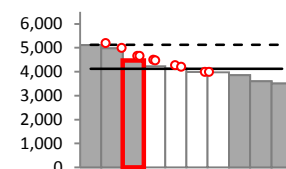
HES

**GP recorded conditions, persons, October 2015 (DSR per 100,000)**

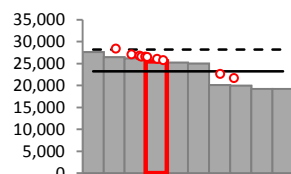
GP data

**Smoking (16y+)**

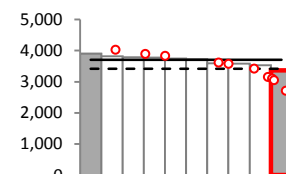
Inner W CC	26,129
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

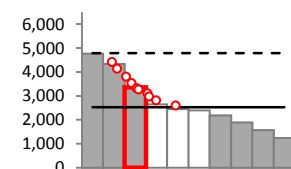
Inner W CC	4,470
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

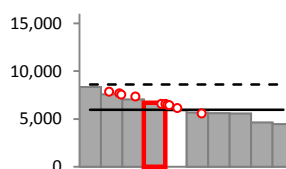
Inner W CC	25,523
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Inner W CC	3,365
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

Inner W CC	3,359
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Inner W CC	6,693
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Inner West Community Committee

The health and wellbeing of the Inner West Community Committee contains very wide variation across the full range of Leeds, and tends predominantly towards ill health. Around 20% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 10 MSOA** areas making up the Community Committee ranges vary widely from almost the shortest life expectancies in Leeds to almost the longest, however, comparing single MSOA level life expectancies is not always suitable***.

Instead, the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 6.2 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and it has significantly lower life expectancy than Leeds for men, women and overall.

The age structure bears a close resemblance to that of Leeds overall. GP recorded ethnicity shows the Community Committee to have slightly larger proportions of "White background" (76%) than Leeds (71%) and lower proportions of other groups. However around a sixth of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is significantly above the Leeds average for men and women, as well as overall for the Community Committee. The *Armley, New Wortley* MSOA in this area has the 3rd and 10th highest all-cause mortality rates for men and women respectively in the city, and the 4th highest rate overall.

Cancer mortality rates are widely spread and significantly higher than Leeds, for men, and overall. Circulatory disease mortality shows a similar widely spread MSOA pattern with the *Burley* area standing out as having the 4th highest male and overall rate in Leeds.

Alcohol specific admissions are significantly above Leeds rates for this Community Committee. The *Armley, New Wortley* area is 4th highest in Leeds overall, and 3rd highest in Leeds for men. Smoking in the MSOAs is all above or very close to the Leeds average, with an overall rate significantly higher than Leeds.

Obesity rates in this Community Committee and most of the MSOAs are significantly above Leeds. COPD and CHD show almost all areas to be significantly above Leeds, with *Armley, New Wortley / Bramley* as the highest in the Community Committee respectively. Diabetes rates are around Leeds average but cancer is the lowest Community Committee rate in Leeds – significantly below Leeds itself, three MSOAs are nearly the lowest in Leeds (*Armley, New Wortley | Bramley Hill Top, Raynville and Wyther Park | Upper Armley*), this is expected as deprived areas often have low GP recorded cancer due to non/late presentation.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 6: Area overview profile for Inner North West Community Committee

This profile presents a high level summary of data sets for the Inner North West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	2,272	41%	67%
Pakistani	690	13%	6%
Black - African	492	9%	5%
Any other Asian background	425	8%	2%
Any other ethnic group	307	6%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	3,310	62%	81%
Arabic	352	7%	1%
Urdu	314	6%	3%
Panjabi	216	4%	1%
Kurdish	138	3%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

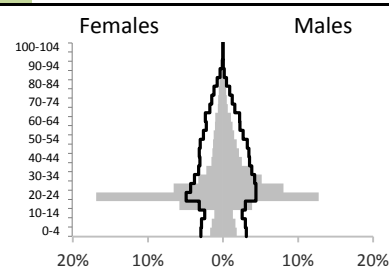
Population: 82,907

41,024

41,883

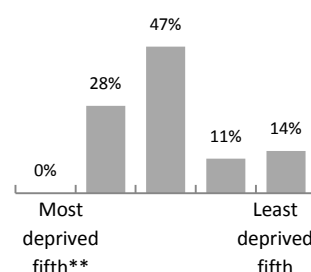
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

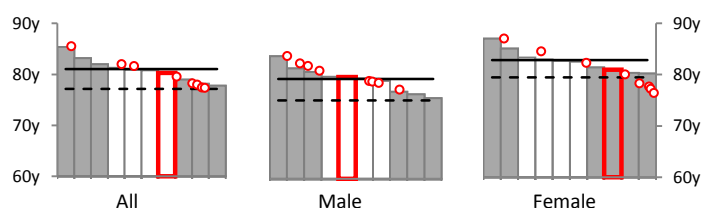


GP recorded ethnicity, top 5	% Area	% Leeds
White British	54%	71%
Other White Background	13%	10%
Other Asian Background	5%	2%
Chinese	5%	1%
Pakistani or British Pakistani	4%	3%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

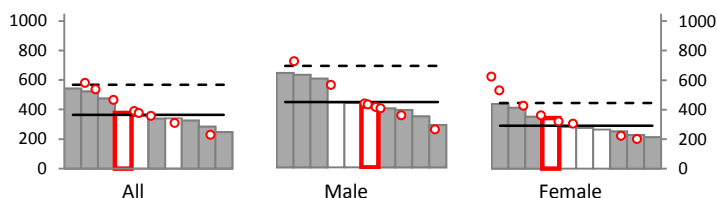
ONS and GP registered populations



(years)	All	Males	Females
Inner North West CC	80.3	79.5	80.9
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

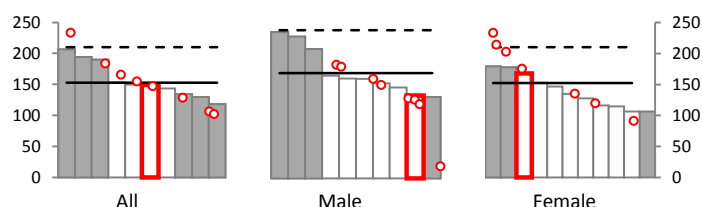
Slope index of inequality (see commentary) = 2.6

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner North West CC	378	413	342
Highest MSOAs in area	578	717	622
Lowest MSOAs in area	225	253	198
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

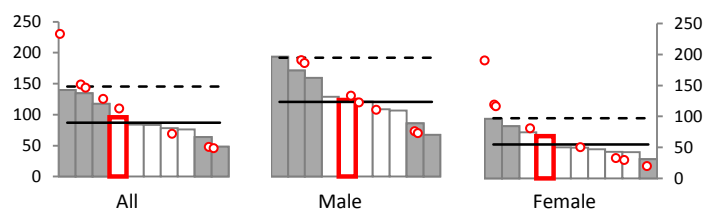


(DSR per 100,000)	All	Males	Females
Inner North West CC	149	134	168
Highest MSOAs in area	233	183	291
Lowest MSOAs in area	102	19	91
Leeds resident	153	170	137
Deprived fifth	210	239	182

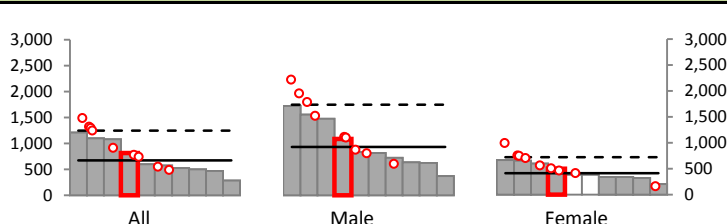
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

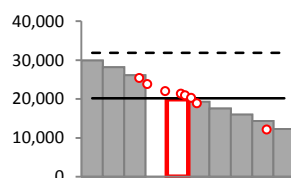
ONS and GP registered populations

**Respiratory disease mortality - under 75s, 2010-14 ranked****Alcohol specific admissions, 2012-14 ranked**

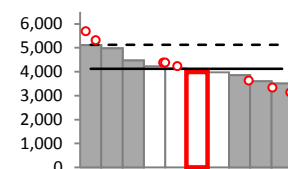
HES

**GP recorded conditions, persons, October 2015 (DSR per 100,000)**

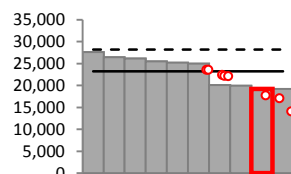
GP data

**Smoking (16y+)**

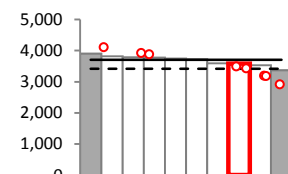
Inner NW CC	19,958
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

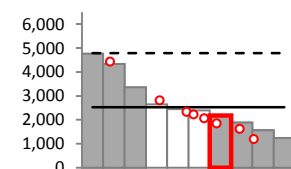
Inner NW CC	3,994
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

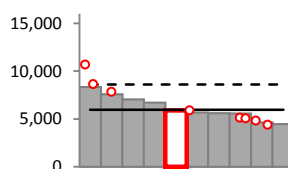
Inner NW CC	19,227
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Inner NW CC	3,579
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

Inner NW CC	2,175
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Inner NW CC	5,902
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Inner North West Community Committee

The health and wellbeing of the Inner North West Community Committee contains very wide variation across the full range of Leeds, overall sitting somewhere in the middle of Leeds. Less than 1% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 8 MSOA** areas making up the Community Committee are widely spread, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 2.6 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is very close to Leeds for men and overall, but with significantly lower life expectancy for women.

The age structure is very different to that of Leeds overall because of the student population. GP recorded ethnicity shows the Community Committee to have smaller proportions of "White background" than Leeds. However around a fifth of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a picture with smaller 'White British' proportions, and larger 'Pakistani', 'Black African' and 'other' groups than Leeds.

All-cause mortality for under 75s is not significantly different to the Community Committee. Cancer mortality rates are very widely spread at MSOA level but the Community Committee rates are mid-range. Circulatory disease mortality shows a wide MSOA pattern with *Little Woodhouse and Burley* and *Headingley Central* the highest in Leeds for men and women respectively. In terms of respiratory mortality, the Community Committee is not significantly different to Leeds, but the MSOAs are very widely spread.

Alcohol specific admissions are significantly above Leeds rates but overall still mid range for the city. Female admissions at MSOA level are almost all above Leeds rates.

GP recorded obesity in the MSOAs is mostly well below the Leeds average, with an overall rate significantly lower than Leeds. Smoking is recorded to be around the Leeds rate. COPD is significantly lower than Leeds but the MSOA *Little London, Sheepscar* stands out as much higher than other parts of the Community Committee. CHD is virtually the same as Leeds, but at MSOA level is extremely widely distributed - *Hyde Park, Burley*, and *West Park and Weetwood* are 3rd highest and 8th highest in Leeds overall.

Diabetes has some MSOA in higher ranks, including *Hyde Park, Burley* which is third highest in the city. Cancer recording in *West Park and Weetwood* is 12th highest in the city.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 7: Area overview profile for Outer West Community Committee

This profile presents a high level summary of data sets for the Outer West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	9,052	80%	67%
Pakistani	526	5%	6%
Indian	355	3%	2%
Any other white background	294	3%	4%
Any other mixed background	154	1%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	9,958	90%	81%
Panjabi	197	2%	1%
Urdu	183	2%	3%
Other than English	144	1%	1%
Polish	115	1%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

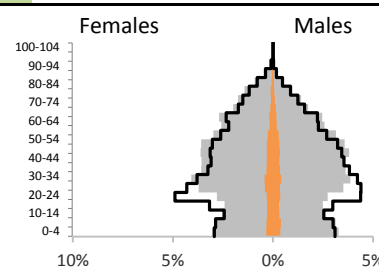
Population: 64,368

32,693

31,675

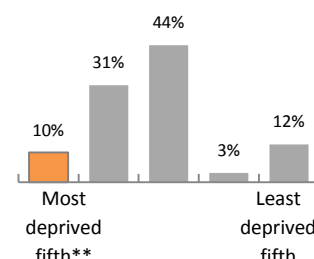
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

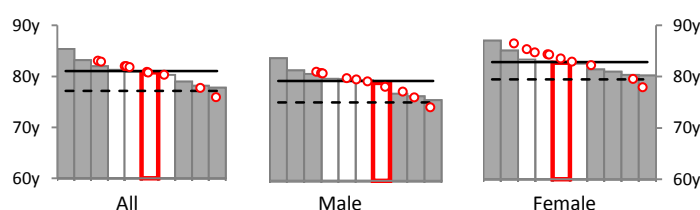


GP recorded ethnicity, top 5	% Area	% Leeds
White British	89%	71%
Other White Background	5%	10%
Indian or British Indian	1%	3%
Black African	1%	3%
Pakistani or British Pakistani	1%	3%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

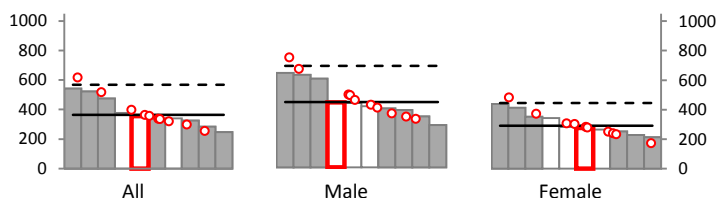
ONS and GP registered populations



(years)	All	Males	Females
Outer West CC	80.8	78.8	82.7
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

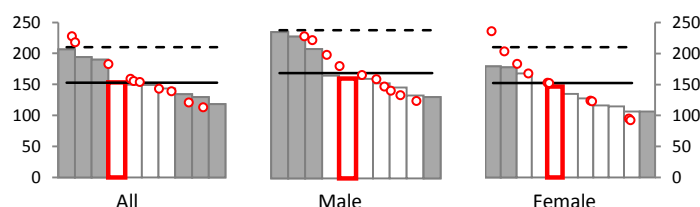
Slope index of inequality (see commentary) = 5.1

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer West CC	356	441	276
Highest MSOAs in area	616	741	481
Lowest MSOAs in area	252	327	171
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

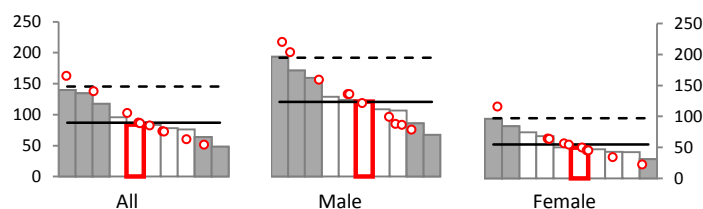


(DSR per 100,000)	All	Males	Females
Outer West CC	153	161	147
Highest MSOAs in area	228	229	236
Lowest MSOAs in area	113	125	92
Leeds resident	153	170	137
Deprived fifth	210	239	182

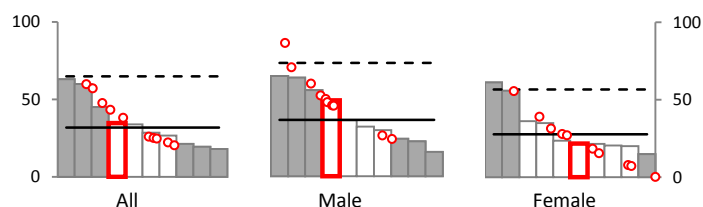
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



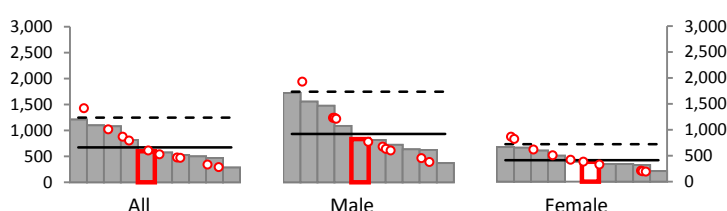
(DSR per 100,000)	All	Males	Females
Outer West CC	84	121	49
Highest MSOAs in area	162	217	116
Lowest MSOAs in area	51	75	22
Leeds resident	87	121	55
Deprived fifth**	145	192	97

Respiratory disease mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Outer West CC	35	49	22
Highest MSOAs in area	60	86	55
Lowest MSOAs in area	20	24	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

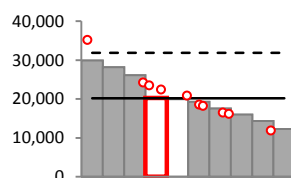
HES



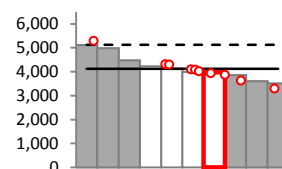
(DSR per 100,000)	All	Males	Females
Outer West AC	602	836	381
Highest MSOAs in area	1,425	1,939	859
Lowest MSOAs in area	289	390	189
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

GP recorded conditions, persons, October 2015 (DSR per 100,000)

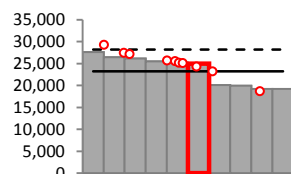
GP data

**Smoking (16y+)**

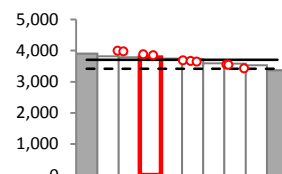
Outer W CC	20,234
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

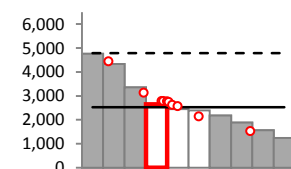
Outer W CC	3,979
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

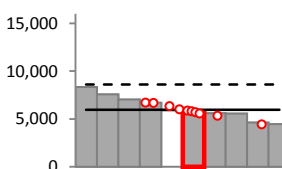
Outer W CC	24,995
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Outer W CC	3,775
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

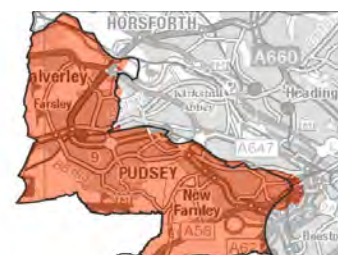
Outer W CC	2,644
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Outer W CC	5,671
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Outer West Community Committee

The health and wellbeing of the Outer West Community Committee contains wide variation across the full range of Leeds, overall looking average for the city. Around 10% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 10 MSOA** areas making up the Community Committee are distributed across Leeds and include quite a wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 5.1 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is very close to Leeds overall.

The age structure bears some resemblance to that of Leeds overall with fewer 15 to 30 year olds. GP recorded ethnicity shows the Community Committee to have slightly larger proportions of "White background" than Leeds. 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey which has a higher rate of recording shows a similar picture with a larger than Leeds proportion of 'White British'.

All-cause mortality for under 75s is very close to the Leeds average for men and women, as well as overall for the Community Committee.

Cancer mortality rates are in the mid range for the city, *Farnley* stands out as being highest above the Leeds rates. Circulatory disease mortality has an MSOA *Farnley*, which is higher than the deprived rate overall. Similarly, respiratory disease mortality rates at the *Farnley* MSOA are higher than deprived Leeds. Alcohol specific admissions are distributed widely, some below and some above Leeds rates, of note again is the *Farnley* MSOA which is very high within Leeds for men, women and overall.

GP recorded obesity is significantly above Leeds but mid range among other Community Committees. Diabetes is significantly below, but very close to Leeds. COPD, CHD, cancer and smoking rates are not really different to Leeds rates.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 8: Area overview profile for Outer North West Community Committee

This profile presents a high level summary of data sets for the Outer North West Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	10,680	87%	67%
Any other white background	338	3%	4%
Any other mixed background	167	1%	2%
Indian	156	1%	2%
White and Asian	143	1%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	11,543	95%	81%
Arabic	117	1%	1%
Polish	40	0%	1%
Farsi Persian (Any Other)	32	0%	0%
Urdu	29	0%	3%

(January 2016, top 5 in Community committee, corresponding Leeds value)

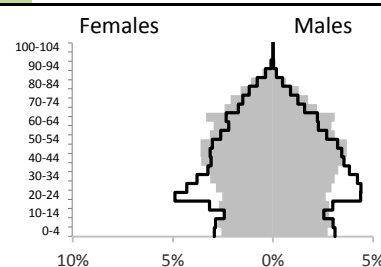
Population: 90,773

45,940

44,833

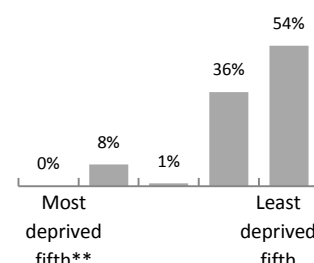
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

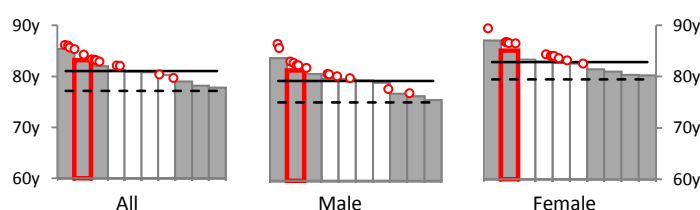


GP recorded ethnicity, top 5	% Area	% Leeds
White British	90%	71%
Other White Background	5%	10%
Indian or British Indian	1%	3%
Other Ethnic Background	1%	2%
Other Asian Background	1%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

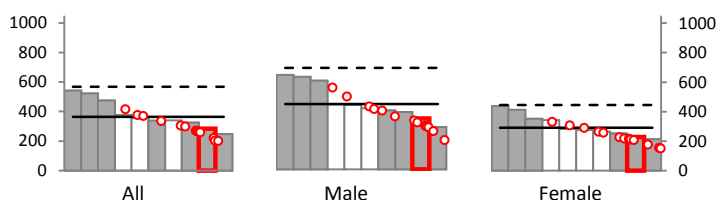
ONS and GP registered populations



(years)	All	Males	Females
Outer North West CC	83.2	81.2	85.1
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

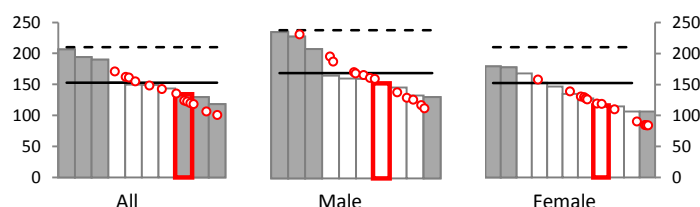
Slope index of inequality (see commentary) = 3.7

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer North West CC	283	344	227
Highest MSOAs in area	414	550	328
Lowest MSOAs in area	199	195	148
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

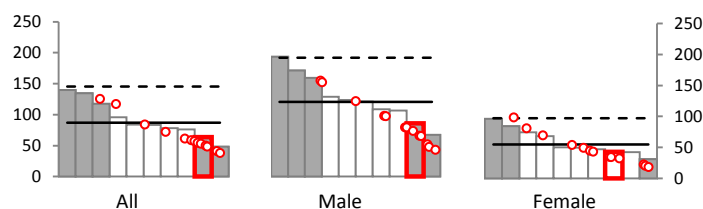


(DSR per 100,000)	All	Males	Females
Outer North West CC	134	154	116
Highest MSOAs in area	170	233	157
Lowest MSOAs in area	100	113	83
Leeds resident	153	170	137
Deprived fifth	210	239	182

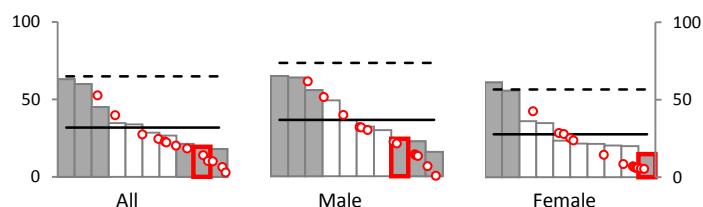
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



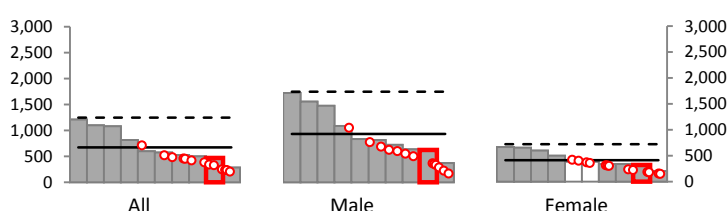
(DSR per 100,000)	All	Males	Females
Outer North West CC	64	86	43
Highest MSOAs in area	125	154	98
Lowest MSOAs in area	38	43	18
Leeds resident	87	121	55
Deprived fifth**	145	192	97

Respiratory disease mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Outer North West CC	19	24	15
Highest MSOAs in area	52	61	42
Lowest MSOAs in area	3	0	5
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

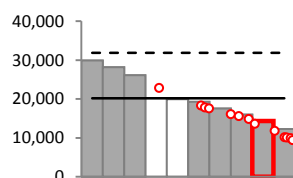
HES



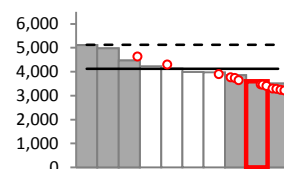
(DSR per 100,000)	All	Males	Females
Outer North West AC	470	626	321
Highest MSOAs in area	708	1,047	416
Lowest MSOAs in area	201	166	147
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

GP recorded conditions, persons, October 2015 (DSR per 100,000)

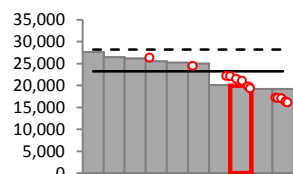
GP data

**Smoking (16y+)**

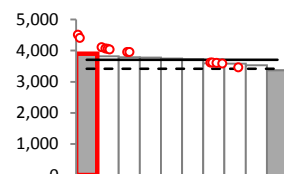
Outer NW CC	14,342
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

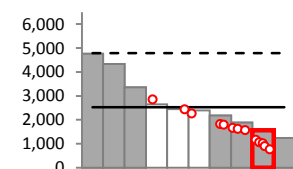
Outer NW CC	3,594
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

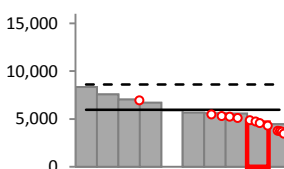
Outer NW CC	19,939
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Outer NW CC	3,896
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

Outer NW CC	1,563
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Outer NW CC	4,626
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Outer North West Community Committee

The health and wellbeing of the Outer North West Community Committee contains wide variation across the full range of Leeds, including extremes, overall in the very healthy range for the city. None of the population live in the most deprived fifth of Leeds*. Life expectancy within the 13 MSOA** areas making up the Community Committee are mainly among the longest in Leeds but do include a reasonably wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 3.7 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is significantly higher than Leeds overall.

The age structure bears little resemblance to that of Leeds overall with fewer young adults and greater proportions of those aged over 40. GP recorded ethnicity shows the Community Committee to have larger proportions of “White background” than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is well below the Leeds average for men and women, as well as overall for the Community Committee. Cancer mortality rates are spread across the mid and low end of Leeds and the Community Committee rates are very low – significantly lower than Leeds for persons. Circulatory disease mortality is mostly gathered around the mid and low end in Leeds – the Community Committee is significantly below Leeds overall, and for men. Respiratory disease mortality rates are slightly more widely spread and very low.

Alcohol specific admissions are concentrated at the low end and mostly significantly lower than Leeds rates. Admissions at Community Committee level are among the very lowest in Leeds. Smoking, obesity, diabetes, CHD and COPD are very low except for the *Yeadon - Henshaws, Southway, Westfields* MSOA which is consistently the highest in the Community Committee.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 9: Area overview profile for Inner South Community Committee

This profile presents a high level summary of data sets for the Inner South Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	7,067	55%	67%
Black - African	1,369	11%	5%
Pakistani	1,162	9%	6%
Any other white background	903	7%	4%
Bangladeshi	463	4%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	8,763	68%	81%
Believed to be Other than English	468	4%	1%
Urdu	463	4%	3%
Other than English	424	3%	1%
Polish	401	3%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

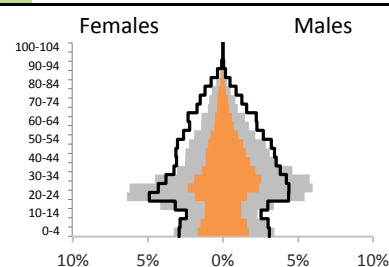
Population: 95,747

46,370

49,377

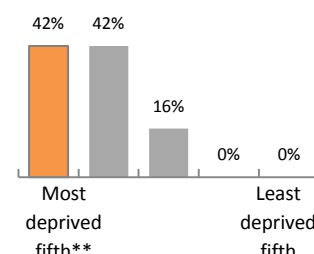
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

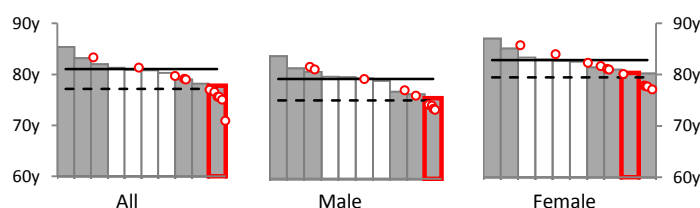


GP recorded ethnicity, top 5	% Area	% Leeds
White British	59%	71%
Other White Background	15%	10%
Black African	6%	3%
Pakistani or British Pakistani	4%	3%
Indian or British Indian	3%	3%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

ONS and GP registered populations



(years)

	All	Males	Females
Inner South CC	77.8	75.5	80.3
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

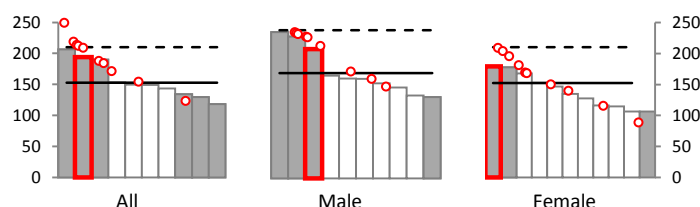
Slope index of inequality (see commentary) = 4.3

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Inner South CC	522	626	412
Highest MSOAs in area	914	1,118	555
Lowest MSOAs in area	378	452	308
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

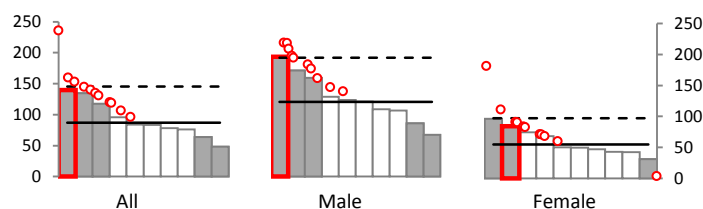


(DSR per 100,000)	All	Males	Females
Inner South CC	194	209	179
Highest MSOAs in area	299	340	267
Lowest MSOAs in area	123	148	88
Leeds resident	153	170	137
Deprived fifth	210	239	182

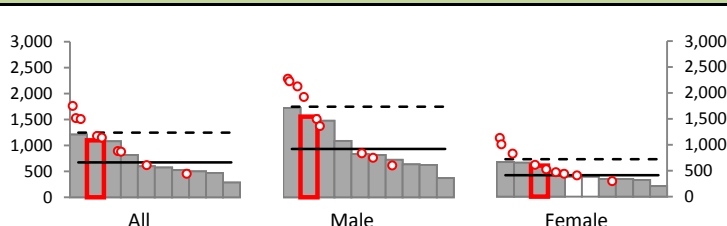
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

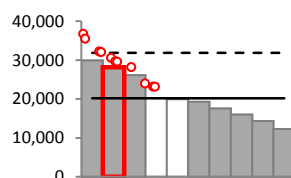
ONS and GP registered populations

**Respiratory disease mortality - under 75s, 2010-14 ranked****Alcohol specific admissions, 2012-14 ranked**

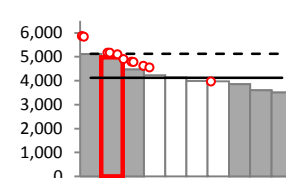
HES

**GP recorded conditions, persons, October 2015 (DSR per 100,000)**

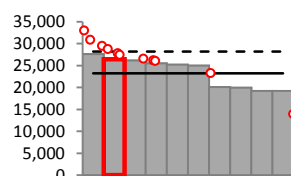
GP data

**Smoking (16y+)**

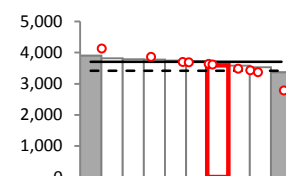
Inner S CC	28,170
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

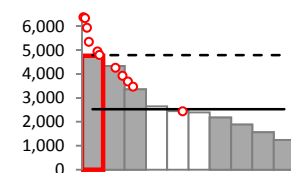
Inner S CC	4,976
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

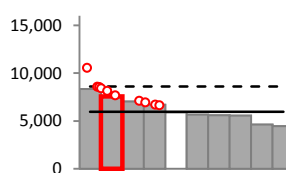
Inner S CC	26,402
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Inner S CC	3,594
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

Inner S CC	4,754
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Inner S CC	7,582
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Inner South Community Committee

The health and wellbeing of the Inner South Community Committee contains some variation across the range of Leeds, but tends overall towards ill health. Around 4 in 10 people live in the most deprived fifth of Leeds*. Life expectancy within the 11 MSOA** areas making up the Community Committee are generally among the shortest in Leeds and significantly lower than Leeds. However, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 4.3 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Overall life expectancy is the shortest of all Community Committees.

The age structure bears a little resemblance to that of Leeds overall with larger proportions of young adults and fewer aged above 40. GP recorded ethnicity shows the Community Committee to have lower proportions of "White background" to Leeds and higher proportions of some BME groups. However around a fifth of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for the Community Committee is significantly above the Leeds average for all, and nearly the very highest in the city. The *city centre* MSOA in this area has the highest rate in the city.

Cancer mortality rates are widely spread at MSOA level and the Community Committee rates are significantly higher than Leeds (female cancer mortality is the highest in the city). Circulatory disease mortality shows an MSOA pattern high above the Leeds averages, with the *Beeston Hill* MSOA standing out as highest in Leeds overall. Respiratory disease mortality rates are very similar and at MSOA level the highest in the city.

Alcohol specific admissions for this Community Committee are very nearly the highest in Leeds, and many of the MSOAs in the area have rates significantly above those of Leeds. Smoking, Obesity, CHD and Diabetes in the MSOAs are almost all significantly above the Leeds average, with the Community Committee rates the 2nd highest in Leeds.

The Community Committee is highest in the city for GP recorded COPD with all but one MSOA being above Leeds. GP recorded cancer is not significantly lower than the city, this is expected as deprived areas often have low GP recorded cancer due to non/late presentation.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 10: Area overview profile for Outer South Community Committee

This profile presents a high level summary of data sets for the Outer South Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	12,223	89%	67%
Any other white background	274	2%	4%
White and Black Caribbean	176	1%	2%
Any other mixed background	166	1%	2%
Indian	155	1%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	12,959	96%	81%
Polish	93	1%	1%
Believed to be English	62	0%	0%
Other than English	52	0%	1%
Panjabi	37	0%	1%

(January 2016, top 5 in Community committee, corresponding Leeds value)

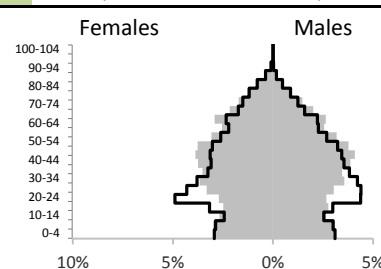
Population: 89,594

45,367

44,227

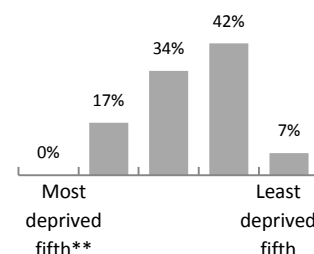
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

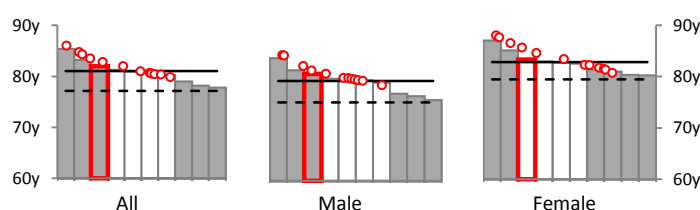


GP recorded ethnicity, top 5	% Area	% Leeds
White British	78%	71%
Other White Background	17%	10%
Indian or British Indian	1%	3%
Chinese	0%	1%
Other Ethnic Background	0%	2%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

ONS and GP registered populations

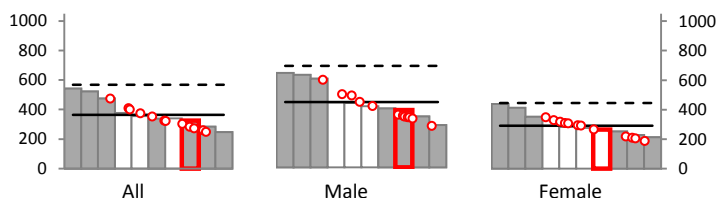


(years)

	All	Males	Females
Outer South CC	82.0	80.5	83.3
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

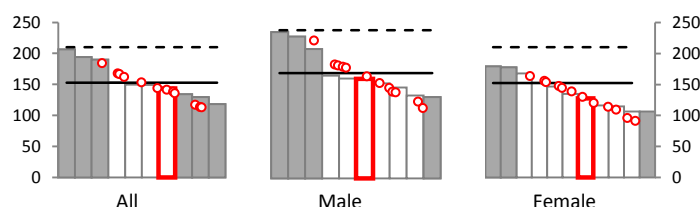
Slope index of inequality (see commentary) = 4.3

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer South CC	325	387	266
Highest MSOAs in area	472	590	347
Lowest MSOAs in area	246	278	185
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

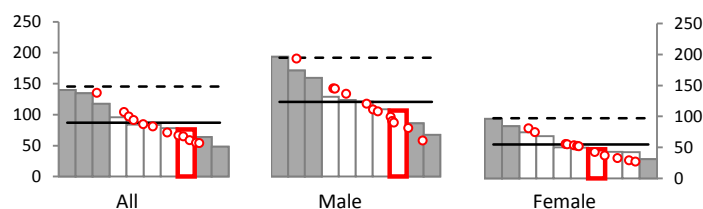


(DSR per 100,000)	All	Males	Females
Outer South CC	144	161	128
Highest MSOAs in area	184	223	163
Lowest MSOAs in area	113	113	90
Leeds resident	153	170	137
Deprived fifth	210	239	182

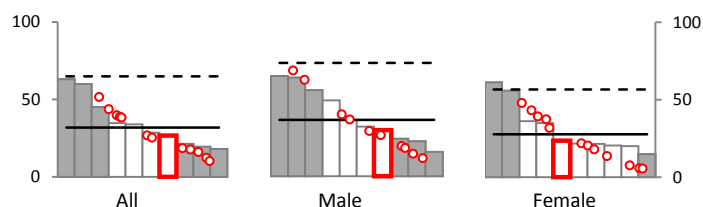
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



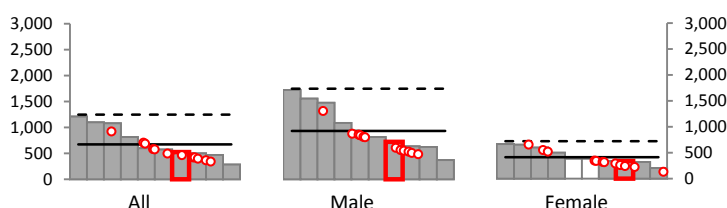
(DSR per 100,000)	All	Males	Females
Outer South CC	76	107	47
Highest MSOAs in area	135	190	80
Lowest MSOAs in area	53	58	27
Leeds resident	87	121	55
Deprived fifth**	145	192	97

Respiratory disease mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Outer South CC	27	30	24
Highest MSOAs in area	51	68	48
Lowest MSOAs in area	10	11	5
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

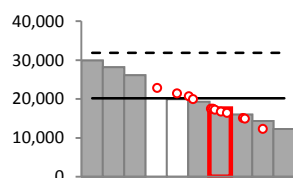
HES



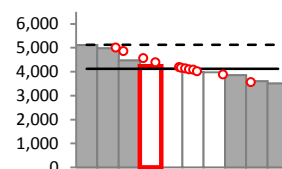
(DSR per 100,000)	All	Males	Females
Outer South AC	524	723	338
Highest MSOAs in area	917	1,313	652
Lowest MSOAs in area	336	480	129
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

GP recorded conditions, persons, October 2015 (DSR per 100,000)

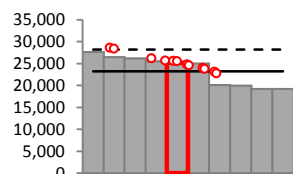
GP data

**Smoking (16y+)**

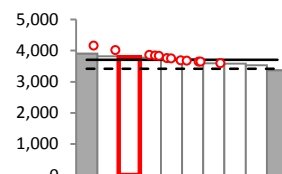
Outer S CC	17,529
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

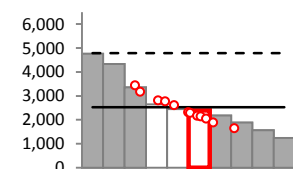
Outer S CC	4,234
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

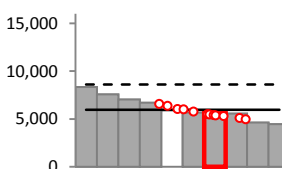
Outer S CC	25,179
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Outer S CC	3,786
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

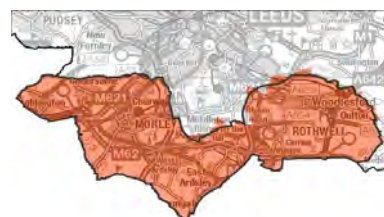
Outer S CC	2,397
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Outer S CC	5,579
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordinance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Outer South Community Committee

The health and wellbeing of the Outer South Community Committee contains relatively wide variation across the range of Leeds, excluding the extremes, and is overall within the mid range for the city. None of the population live in the most deprived fifth of Leeds*. Life expectancy within the 12 MSOA** areas making up the Community Committee are mainly among the longest in Leeds but do include a wide variation, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 4.3 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and was significantly higher than Leeds overall and for men.

The age structure bears little resemblance to that of Leeds overall with fewer young adults and greater proportions of those aged between 40 and 74. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a clearer but similar picture.

All-cause mortality for under 75s for the Community Committee is significantly below the Leeds average for men and overall. The MSOA *Morley West* is significantly higher than Leeds overall and for men.

Cancer mortality rates are widely spread at MSOA level, the Community Committee rates are average. Circulatory disease mortality is mostly gathered around the mid range in Leeds. Respiratory disease mortality rates are slightly more widely spread but Committee level rates are very low.

Alcohol specific admissions are mostly concentrated around the mid range and almost all are significantly below Leeds rates. Much of the GP audit data for this Community Committee is mid range for the city. GP recorded smoking, and diabetes are significantly lower than Leeds, whereas obesity is significantly higher than Leeds.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 11: Area overview profile for Outer East Community Committee

This profile presents a high level summary of data sets for the Outer East Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a dark grey bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

Pupil ethnicity, top 5	Area	% Area	% Leeds
White - British	11,896	86%	67%
Black - African	345	3%	5%
Any other white background	278	2%	4%
Unknown	187	1%	1%
White and Black Caribbean	173	1%	2%

(January 2016, top 5 in Community committee, corresponding Leeds value)

Pupil language, top 5	Area	% Area	% Leeds
English	12,688	95%	81%
Polish	109	1%	1%
Other than English	92	1%	1%
French	40	0%	1%
Believed to be English	37	0%	0%

(January 2016, top 5 in Community committee, corresponding Leeds value)

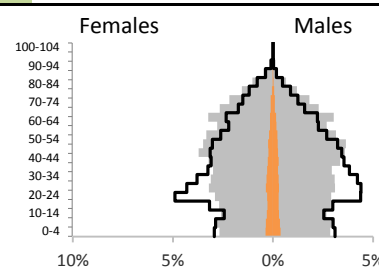
Population: 83,454

42,488

40,966

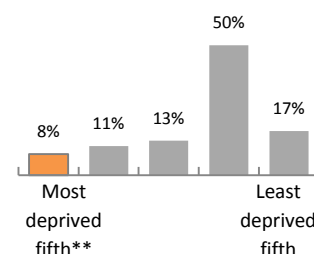
Comparison of Community Committee and Leeds age structures in October 2015.

Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.



Deprivation distribution

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), October 2015.

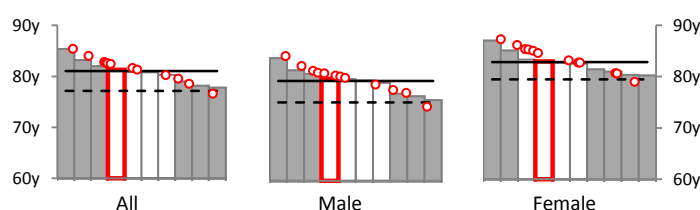


GP recorded ethnicity, top 5	% Area	% Leeds
White British	91%	71%
Other White Background	4%	10%
Black African	1%	3%
Indian or British Indian	1%	3%
White Irish	0%	1%

(October 2015, top 5 in Community committee, corresponding Leeds values)

Life expectancy at birth, 2012-14 ranked Community Committees

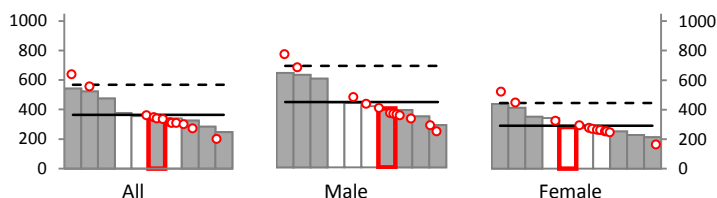
ONS and GP registered populations



(years)	All	Males	Females
Outer East CC	81.3	79.6	83.0
Leeds resident	81.0	79.2	82.8
Deprived Leeds*	77.1	75.0	79.5

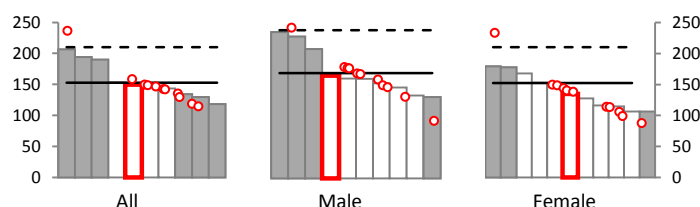
Slope index of inequality (see commentary) = 3.8

All cause mortality - under 75s, 2010-14 ranked. Directly age Standardised Rates (DSRs)



(DSR per 100,000)	All	Males	Females
Outer East CC	338	399	282
Highest MSOAs in area	636	765	520
Lowest MSOAs in area	199	240	162
Leeds resident	365	441	291
Deprived fifth**	567	687	444

Cancer mortality - under 75s, 2010-14 ranked

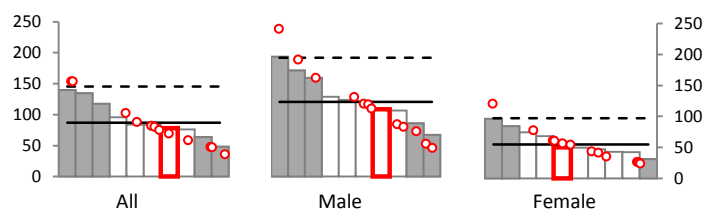


(DSR per 100,000)	All	Males	Females
Outer East CC	150	166	135
Highest MSOAs in area	266	260	276
Lowest MSOAs in area	114	93	87
Leeds resident	153	170	137
Deprived fifth	210	239	182

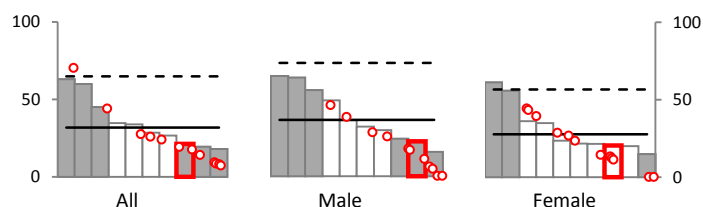
DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

Circulatory disease mortality - under 75s, 2010-14 ranked

ONS and GP registered populations



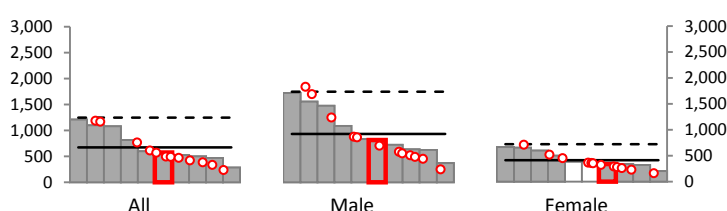
(DSR per 100,000)	All	Males	Females
Outer East CC	78	109	50
Highest MSOAs in area	153	238	120
Lowest MSOAs in area	35	46	23
Leeds resident	87	121	55
Deprived fifth**	145	192	97

Respiratory disease mortality - under 75s, 2010-14 ranked

(DSR per 100,000)	All	Males	Females
Outer East CC	21	22	20
Highest MSOAs in area	70	105	44
Lowest MSOAs in area	7	0	0
Leeds resident	32	36	28
Deprived fifth	65	73	57

Alcohol specific admissions, 2012-14 ranked

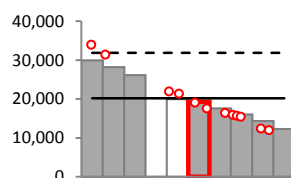
HES



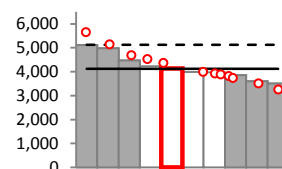
(DSR per 100,000)	All	Males	Females
Outer East AC	574	818	340
Highest MSOAs in area	1,182	1,837	705
Lowest MSOAs in area	235	248	157
Leeds resident	673	934	412
Deprived Leeds*	1,249	1,752	722

GP recorded conditions, persons, October 2015 (DSR per 100,000)

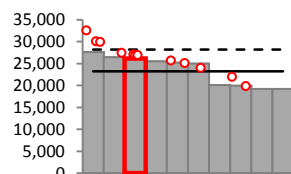
GP data

**Smoking (16y+)**

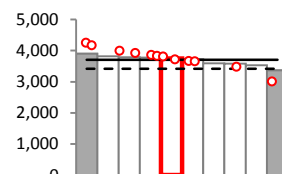
Outer E CC	19,277
Leeds	20,165
Deprived Leeds *	31,829

**CHD**

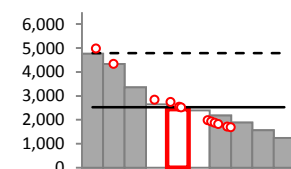
Outer E CC	4,129
Leeds	4,126
Deprived Leeds *	5,122

**Obesity (16y+ and BMI>30)**

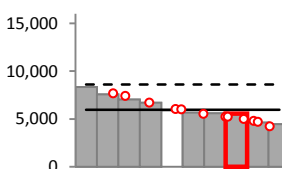
Outer E CC	26,110
Leeds	23,226
Deprived Leeds *	28,196

**Cancer**

Outer E CC	3,752
Leeds	3,703
Deprived Leeds *	3,419

**COPD**

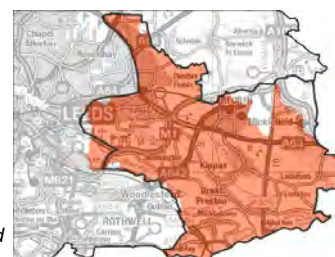
Outer E CC	2,450
Leeds	2,532
Deprived Leeds *	4,792

**Diabetes**

Outer E CC	5,570
Leeds	5,977
Deprived Leeds *	8,603

The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. However, some areas of Leeds have low numbers of patients registered at Leeds practices; if too few then their data is excluded from the data here. Obesity here is the rate within the population who have a recorded BMI.

Map shows this Community Committee as a black outline, the combined best match MSOAs used in this report are the shaded area. ***Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation. ****Most deprived fifth (quintile) of Leeds** - Leeds split into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSA2011 areas. **Ordnance Survey** PSMA Data, Licence Number 100050507, (c) Crown Copyright 2011, All rights reserved. **GP data** courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city. **Admissions data** Copyright © 2016, re-used with the permission of the Health and Social Care Information Centre (HSCIC) / NHS Digital. All rights reserved.



Outer East Community Committee

The health and wellbeing of the Outer East Community Committee contains very wide variation across the full range of Leeds, overall in the mid range for the city. Only 8% of the population live in the most deprived fifth of Leeds*. Life expectancy within the 12 MSOA** areas making up the Community Committee ranges vary widely including almost the shortest male life expectancy in Leeds, however, comparing single MSOA level life expectancies is not always suitable***.

Instead the Slope Index of Inequality (Sii****) is used as a measure of health inequalities in life expectancy at birth within a local area taking into account the whole population experience, not simply the difference between the highest and lowest MSOAs. The Sii for this Community Committee is 3.8 years and can be interpreted as the difference in life expectancy between the most and least deprived people in the Community Committee. Life expectancy was also calculated for the Community Committee (at which level it becomes more reliable), and is not significantly different to Leeds overall.

The age structure bears little resemblance to that of Leeds overall with fewer young adults and greater proportions of those aged over 40. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 16% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a similar picture.

All-cause mortality for under 75s is around the Leeds average for men and women, as well as overall for the Community Committee. The *Swarcliffe* MSOA in this area has highest rates in the Community Committee for men, women, and overall.

Cancer mortality rates are widely spread and the Community Committee rates are not significantly different to Leeds. One MSOA, *Swarcliffe* has the 3rd highest overall rate and 2nd highest female rates in the city. Circulatory disease mortality shows a similar widely spread MSOA pattern with the *Swarcliffe* area again standing out as having a very high rate. The *Halton moor, Wykebecks* MSOA has a male respiratory disease mortality rate that is 6th highest in the city (not charted as off the scale) but overall the Community Committee has low rates.

Alcohol specific admissions are significantly below Leeds rates for this Community Committee, and MSOA rates are well distributed around the Leeds rates but including some extremes such as *Halton Moor, Wykebecks*. Smoking rates in four of the twelve MSOAs are above Leeds, the *Halton Moor, Wykebecks* MSOA is actually fifth highest in Leeds, but overall the Community Committee rate is just significantly below Leeds.

Obesity rates in this Community Committee and almost all the MSOAs are significantly above Leeds, including *Swarcliffe* MSA with the second highest obesity rate in the city. COPD and CHD are both around the Leeds value but again the *Halton Moor, Wykebecks* MSOA is the highest with rates near the largest in Leeds. GP recorded cancer is no different to Leeds overall, there are some high MSOAs with *Allerton Bywater, Methley and Mickletown* having the 5th highest rate in the city.

***Deprived fifth of Leeds:** The fifth of Leeds which are most deprived according to the 2015 Index of Multiple Deprivation, using MSOAs.

****MSOA:** Middle Super Output Area, small areas of England to enable data processing at consistent and relatively fine level of detail.

MSOAs each have a code number such as E02002300, and locally they are named, in this sheet their names are in italics. MSOAs used in this report are the post 2011 updated versions; 107 in Leeds. *****Life expectancy:** Life expectancy calculations are most accurate where the age structure of, and deaths within, of the subject area are regular. At MSOA level there are some extreme cases where low numbers of deaths and age structures very different to normal produce inconsistent LE estimates. So while a collection of MSOA life expectancy figures show us information on the city when they are brought together, as single items they are not suitable for comparison to another. This report displays Community Committee level life expectancy instead, and uses the MSOA calculations to produce the Slope Index of Inequality. ******Slope Index of Inequality:** more details here <http://www.instituteofhealthequity.org/projects/the-slope-index-of-inequality-sii-in-life-expectancy-interpreting-it-and-comparisons-across-london>. For this profile, MSOA level deprivation was calculated with July 2013 population weighted 2015IMD LSOA deprivation scores and MSOA level life expectancy in order to create the Sii.

Appendix 12: Leeds housing and mixed use development areas as of mid July 2017

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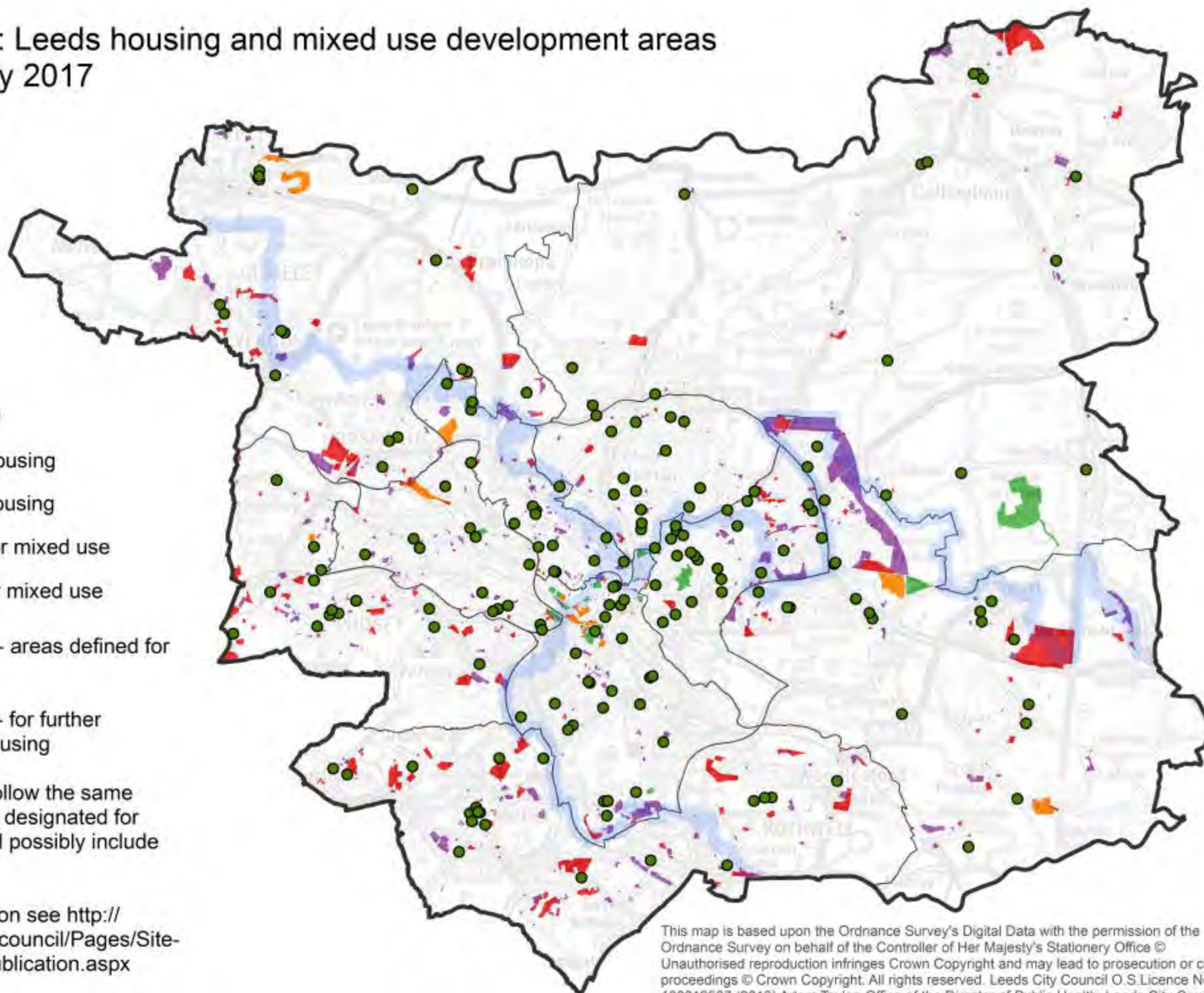
-  Pharmacies
-  Allocated housing
-  Identified housing
-  Allocated for mixed use
-  Identified for mixed use

Allocated housing - areas defined for housing

Identified housing - for further investigation as housing

Mixed use areas follow the same convention but are designated for many uses and will possibly include housing.

For more information see <http://www.leeds.gov.uk/council/Pages/Site-allocations-plan-publication.aspx>



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Appendix 13: Overview report
PNA 2017 Pharmacy Survey

Responses Received		
Online	Paper - DE	Total
60	94	154

	Total	%	
Q1 Please provide your ODS Code			
Responses received	154	100.0%	
NR	0		
	154		
Q2 Is your pharmacy...			
A 100 hour pharmacy	22	14.3%	
A distance selling pharmacy	3	1.9%	
An LPS pharmacy	62	40.3%	
NR	67	43.5%	
	154		
Q3 What is your pharmacy's Healthy Living status?			
The pharmacy has achieved HLP Level 1 status	52	33.8%	
The pharmacy is working towards HLP Level 1 status	84	54.5%	
The pharmacy is not currently working towards HLP Level 1 status	13	8.4%	
NR	5	3.2%	
	154		
Q3a If the pharmacy is working towards HLP Level 1 status, please state the date you expect to achieve this:			
Responses received	48	57.1%	
NR	36	42.9%	
	84		
Q4 Is the address to which this questionnaire was sent correct?			
Yes	125	81.2%	
No	27	17.5%	
NR	2	1.3%	
	154		
Q4a If no, please provide the correct address below			
Responses received	27	100.0%	
NR	0		
	27		
Q5 Do your opening hours match those that we enclose in the covering letter?			
Yes	106	68.8%	
No	47	30.5%	
NR	1	0.6%	
	154		
Q6 If no, please provide the correct opening hours below:			
Q6a Monday - Friday			
Responses received	46		
Q6b Saturday			
Responses received	45		
Q6c Sunday			
Responses received	43		
Q6d If you know your Core Hours, please provide			
Responses received	27		
Q7 Which of these advanced services do you currently provide? Please tick all that apply		% of responses	% of respondents
Medicines use review	148	32.7%	96.1%
New medicines service	146	32.2%	94.8%
NHS Urgent Medicine Supply Advanced Service (NUMSAS)	28	6.2%	18.2%
Appliance use reviews	9	2.0%	5.8%
Stoma appliance customisation	6	1.3%	3.9%
NHS Flu vaccinations	114	25.2%	74.0%
None of these	2	0.4%	1.3%
	453		

Q8	Does the pharmacy dispense appliances?			
	Yes – all types	124	80.5%	
	Yes – excluding stoma appliances	3	1.9%	
	Yes – excluding incontinence appliances	1	0.6%	
	Yes – excluding stoma and incontinence appliances	1	0.6%	
	Yes – just dressings	15	9.7%	
	No	10	6.5%	
		154		
Q9	Which of these locally commissioned services do you CURRENTLY provide? Please tick all that apply		% of responses	% of respondents
	Stop Smoking Advice	28	5.9%	18.2%
	Nicotine Replacement Therapy	68	14.3%	44.2%
	Supervised consumption scheme	133	27.9%	86.4%
	Chlamydia Screening	11	2.3%	7.1%
	Emergency Hormonal Contraception	36	7.5%	23.4%
	Pregnancy Testing	20	4.2%	13.0%
	Needle exchange Service	11	2.3%	7.1%
	Pharmacy First Service	106	22.2%	68.8%
	NHS England Minor Ailment Service	64	13.4%	41.6%
		477		
Q10	Are you providing any of the following services on a private or unpaid basis? Please tick all that apply		% of responses	% of respondents
	Diabetes checks/management	48	7.7%	31.2%
	Inhaler reviews	49	7.9%	31.8%
	Asthma	30	4.8%	19.5%
	COPD	19	3.1%	12.3%
	Palliative care medicines	37	5.9%	24.0%
	Alcohol Brief Advice	8	1.3%	5.2%
	Free delivery of medicine to patient's home	129	20.7%	83.8%
	Falls Prevention Service	1	0.2%	0.6%
	Prescription collection service	137	22.0%	89.0%
	Weight management	30	4.8%	19.5%
	Blood pressure testing	112	18.0%	72.7%
	Other	22	3.5%	14.3%
		622		
Q10a	If other, please state			
	Responses received	22	100.0%	
	NR	0		
		22		
Q11	Are there any gaps in services that you would want to provide if commissioned to do so?			
	Responses received	64	41.6%	
	NR	90	58.4%	
		154		
Q12	Has the extended opening hours of GP surgeries had an impact on the services you provide?			
	Yes	13	8.4%	
	No	140	90.9%	
	NR	1	0.6%	
		154		
Q12a	If yes, please describe what the impact has been			
	Responses received	12	92.3%	
	NR	1	7.7%	
		13		
Q13	Are you a member of the following schemes?			
Q13a	Stay Safe Scheme			
	Yes	9	5.8%	
	No	119	77.3%	
	NR	26	16.9%	
		154		
Q13b	Dementia Friendly Scheme			
	Yes	143	92.9%	
	No	9	5.8%	
	NR	2	1.3%	
		154		

Q14	Please confirm if the following are applicable to your pharmacy...		
Q14a	The entrance to the pharmacy is suitable for unaided disabled access		
	Yes	122	79.2%
	No	31	20.1%
	NR	1	0.6%
		154	
Q14b	All areas of the pharmacy floor are accessible by wheelchair		
	Yes	146	94.8%
	No	6	3.9%
	NR	2	1.3%
		154	
Q14c	Customers can legally park within 50 metres of the pharmacy		
	Yes	143	92.9%
	No	10	6.5%
	NR	1	0.6%
		154	
Q14d	Disabled customers (who have a blue badge) can park within 10 metres of the pharmacy		
	Yes	120	77.9%
	No	32	20.8%
	NR	2	1.3%
		154	
Q15	What facilities do you have in the pharmacy aimed at helping disabled people access your services?	% of responses	% of respondents
	Please tick all that apply		
	Automatic door assistance	60	14.4%
	Bell at front door	44	10.5%
	Disabled toilet facility	21	5.0%
	Hearing loop	89	21.3%
	Large print labels/leaflets	75	17.9%
	Non-stick tops	51	12.2%
	Wheelchair ramp access	64	15.3%
	Other	14	3.3%
		418	
Q15a	If other, please specify		
	Responses received	13	92.9%
	NR	1	7.1%
		14	
Q16	Is there a bus stop or other public transport stop within walking distance of the pharmacy?		
	Yes	149	96.8%
	No	2	1.3%
	NR	3	1.9%
		154	
Q17	If there is a bus stop or other public transport stop, how long (walking at a moderate pace) does the walk take?		
	Less than 2 minutes	109	70.8%
	2 to 5 minutes	36	23.4%
	More than 5 minutes	3	1.9%
	NR	6	3.9%
		154	
Q17a	If more than 5 minutes, please state how long approximately		
	Responses received	3	100.0%
	NR	0	
		3	
Q18	Do you feel that the pharmacy premises are suitable for services planned in the future?		
	Yes	141	91.6%
	No	10	6.5%
	NR	3	1.9%
		154	
Q19	Are there any restrictions on the changes you can make to your premises?		
	Yes	35	22.7%
	No	117	76.0%
	NR	2	1.3%
		154	

Q19a	If yes, please state briefly what these are		
	Responses received	32	91.4%
	NR	3	8.6%
		35	
Q20	Do you have a separate area/room suitable for private consultations with customers?		
	Yes	147	95.5%
	No	7	4.5%
	NR	0	0.0%
		154	
Q21	If you do have a separate area/room suitable for private consultations with customers, do any of the below apply:		
Q21a	It is accessible for someone who uses a wheelchair		
	Yes	131	85.1%
	No	13	8.4%
	NR	10	6.5%
		154	
Q21b	Seating is provided		
	Yes	145	94.2%
	No	0	0.0%
	NR	9	5.8%
		154	
Q21c	There is a computer terminal within the area to access patients' records / complete audit data		
	Yes	119	77.3%
	No	26	16.9%
	NR	9	5.8%
		154	
Q21d	There are handwashing facilities, or there is access to hand sanitiser gel nearby		
	Yes	132	85.7%
	No	13	8.4%
	NR	9	5.8%
		154	
Q22	Do any of your regular pharmacists or pharmacy staff speak a foreign language?		
	Yes	93	60.4%
	No	61	39.6%
	NR	0	0.0%
		154	

Q23	If yes, which languages are spoken? please tick all that apply	% of responses	% of respondents
	Arabic	9	3.2%
	Bengali	8	2.9%
	Cantonese	2	0.7%
	Czech	2	0.7%
	Farsi	4	1.4%
	French	8	2.9%
	German	3	1.1%
	Hakka	0	0.0%
	Hindi	32	11.5%
	Lithuanian	1	0.4%
	Japanese	0	0.0%
	Kurdish	1	0.4%
	Mandarin	2	0.7%
	Mirpuri	29	10.4%
	Greek	6	2.2%
	Gujrati	19	6.8%
	Polish	8	2.9%
	Punjabi	50	17.9%
	Potwar	10	3.6%
	Romanian	0	0.0%
	Russian	0	0.0%
	Serbian	1	0.4%
	Somali	0	0.0%
	Spanish	8	2.9%
	Swahili	4	1.4%
	Urdu	54	19.4%
	Other	18	6.5%
		279	

Q23a	If other, please specify:		
	Responses received	0	0.0%
	NR	18	100.0%
		18	
Q24	Have any of your staff received Equality and Diversity awareness training?		
	Yes - all of the staff	34	22.1%
	Yes - some of the staff	29	18.8%
	No - none of the staff	90	58.4%
	NR	1	0.6%
		154	
Q25	Using the results from your most recent CPPQ, please identify the most frequent requests from patients as either improvements or additions to services:		
	Responses received	136	88.3%
	NR	18	11.7%
		154	
Q26	Details of person completing this form...		
Q26a	Name		
	Responses received	154	
Q26b	Signature		
	Responses received	0	
Q26c	Date completed		
	Responses received	154	
Q26d	Role		
	Responses received	154	
Q26e	Telephone number		
	Responses received	152	

Appendix 14: Overview report - Public
Leeds Pharmacy Services Public Consultation 2017

Responses Received		
Online	Paper	Total
1059	365	1424

Q1 Do you use your local (closest to where you live) pharmacy?

Yes
No
NR

Total	%
1070	75.1%
321	22.5%
33	2.3%
1424	

Q2 Thinking about the pharmacy you use the most, why do you use it? Please tick all that apply

Q2:1 It is the closest to where I live
Q2:2 It is the closest to where I work
Q2:3 It is the closest to my GP surgery
Q2:4 The pharmacy opening hours are convenient for me
Q2:5 I have a good relationship with the pharmacy and the staff there
Q2:6 Staff are able to speak to me in a language other than English
Q2:7 I can access general health and medicines advice
Q2:8 I can purchase other retail items (e.g. cosmetics or groceries) at the same time
Q2:9 I use it when convenient to do so, but also use others when out and about
Q2:10 Other

	% of responses	% of respondents
866	22.1%	60.8%
57	1.5%	4.0%
808	20.6%	56.7%
531	13.6%	37.3%
532	13.6%	37.4%
15	0.4%	1.1%
409	10.5%	28.7%
313	8.0%	22.0%
324	8.3%	22.8%
58	1.5%	4.1%
3913		

Q2a If other, please briefly describe

Response Received
NR

57	98.3%
1	1.7%
58	

Q3 Is there anything stopping you from visiting your local pharmacy?

Yes
No
NR

184	12.9%
1220	85.7%
20	1.4%
1424	

Q3a If yes, please specify

Response Received
NR

175	95.1%
9	4.9%
184	

Q4 Do you have a choice about which pharmacy you use?

Yes
No
NR

1348	94.7%
66	4.6%
10	0.7%
1424	

Q4a If no, please provide further detail

Response Received
NR

47	71.2%
19	28.8%
66	

Q5 Can you find a pharmacy open in the evening if you need one?

Yes
No
NR

1117	78.4%
254	17.8%
53	3.7%
1424	

Q6 Can you find a pharmacy open on a Sunday or a Bank Holiday if you need one?

Yes
No
NR

1051	73.8%
298	20.9%
75	5.3%
1424	

Q7 Please rate the availability and quality of pharmacies in your area:

Q7a Overall, the availability of pharmacies in your area is...

Very good	597	41.9%
Good	536	37.6%
Okay	238	16.7%
Bad	20	1.4%
Very bad	3	0.2%
NR	30	2.1%
	1424	

Q7b Overall, the quality of pharmacies in your area is...

Very good	514	36.1%
Good	572	40.2%
Okay	236	16.6%
Bad	17	1.2%
Very bad	8	0.6%
NR	77	5.4%
	1424	

Which of the following are important to you when thinking about your use of pharmacies? Please

Q8 tick all that apply

		% of responses	% of respondents
Q8:1	Opening before 9am	375	4.4%
Q8:2	Opening after 7pm	510	6.0%
Q8:3	Saturday opening	783	9.3%
Q8:4	Sunday opening	515	6.1%
Q8:5	Convenient location	1130	13.4%
Q8:6	Staff knowledge	861	10.2%
Q8:7	Friendly staff	879	10.4%
Q8:8	Shorter waiting times	449	5.3%
Q8:9	Private areas to speak to the pharmacist/other pharmacy staff	566	6.7%
Q8:10	Pharmacist/other pharmacy staff take time to listen	543	6.4%
Q8:11	Pharmacy has the things you need	700	8.3%
Q8:12	Pharmacy collects your prescription from your GP	788	9.3%
Q8:13	Home delivery service	322	3.8%
Q8:14	Other	32	0.4%
	8453		

Q8a If other, please specify

Responses Received	32	100.0%
NR	0	0.0%
	32	

How often do you use a pharmacy for medication, prescriptions or other purposes, e.g. self care advice or to buy medicines? Think about when you go to the pharmacy yourself, when someone goes for you, or when the pharmacy delivers your medications to you.

Q9	Every week	97	6.8%
	Every month	642	45.1%
	Every couple of months	461	32.4%
	Once or twice each year	151	10.6%
	Less often	66	4.6%
	NR	7	0.5%
	1424		

Q10 What type of pharmacy do you usually use?

One on a local high street	530	37.2%
One in a supermarket	140	9.8%
Pharmacy in or next to a doctor's surgery	657	46.1%
Pharmacy in a large retail park	37	2.6%
One on the internet	2	0.1%
Other	53	3.7%
NR	5	0.4%
	1424	

Q10a If other, please specify

Responses Received	50	94.3%
NR	3	5.7%
	53	

Q11	How do you travel to your local (or usual) pharmacy?		
	Car	717	50.4%
	Public transport	75	5.3%
	Walking	587	41.2%
	Other (e.g. bicycle)	38	2.7%
	NR	7	0.5%
		1424	
Q11a	If other, please specify		
	Responses Received	35	92.1%
	NR	3	7.9%
		38	
Q12	If you travel by car, can you legally park within 50 metres of the pharmacy?		
	Yes	977	68.6%
	No	60	4.2%
	Don't know	92	6.5%
	NR	295	20.7%
		1424	
Q13	If you have a blue badge, can you park within 10 metres of the pharmacy?		
	Yes	322	22.6%
	No	119	8.4%
	Don't know	357	25.1%
	NR	626	44.0%
		1424	
Q14	How long does it take you to get to your pharmacy?		
	Up to 10 minutes	1035	72.7%
	11 – 20 minutes	319	22.4%
	21 – 30 minutes	45	3.2%
	Over 30 minutes	13	0.9%
	NR	12	0.8%
		1424	
Q15	Is there public transport within walking distance of the pharmacy?		
	Yes	1237	86.9%
	No	83	5.8%
	Don't know	81	5.7%
	NR	23	1.6%
		1424	

Q16	Do you have any difficulties travelling to pharmacies near you?		
	Yes – I have problems parking	51	3.6%
	Yes – public transport does not run regularly	16	1.1%
	Yes – public transport is too expensive	8	0.6%
	No – I don't have any difficulties	1232	86.5%
	No – I use the delivery service	74	5.2%
	Other	31	2.2%
	NR	12	0.8%
		1424	
Q16a	If other, please specify		
	Responses Received	30	96.8%
	NR	1	3.2%
		31	
Q17	If you walk to the pharmacy, how long (walking at a moderate pace) does the walk take?		
	Less than 2 minutes	50	3.5%
	More than 2 minutes but less than 5 minutes	232	16.3%
	More than 5 minutes	903	63.4%
	NR	239	16.8%
		1424	
Q17a	If more than 5 minutes, please state how many minutes (approximately):		
	Responses Received	770	85.3%
	NR	133	14.7%
		903	
Q18a	Alcohol support services		
	Regularly	3	0.2%
	Sometimes	3	0.2%
	Never	1089	76.5%
	NR	329	23.1%
		1424	
Q18	Which of the following services (if available) do you use at your local (or usual) pharmacy?		
Q18b	Asthma advice/care		
	Regularly	39	2.7%
	Sometimes	86	6.0%
	Never	985	69.2%
	NR	314	22.1%
		1424	
Q18c	Blood pressure checking service		
	Regularly	41	2.9%
	Sometimes	136	9.6%
	Never	954	67.0%
	NR	293	20.6%
		1424	
Q18d	Buying over the counter medicines		
	Regularly	223	15.7%
	Sometimes	903	63.4%
	Never	167	11.7%
	NR	131	9.2%
		1424	
Q18e	Cancer treatment support service		
	Regularly	8	0.6%
	Sometimes	16	1.1%
	Never	1072	75.3%
	NR	328	23.0%
		1424	
Q18f	Chlamydia screening		
	Regularly	2	0.1%
	Sometimes	5	0.4%
	Never	1088	76.4%
	NR	329	23.1%
		1424	

Q18g	COPD advice		
	Regularly	13	0.9%
	Sometimes	31	2.2%
	Never	1052	73.9%
	NR	328	23.0%
		1424	
Q18h	Diabetes screening service		
	Regularly	17	1.2%
	Sometimes	44	3.1%
	Never	1039	73.0%
	NR	324	22.8%
		1424	
Q18i	Disposal of old, or unwanted medicines		
	Regularly	69	4.8%
	Sometimes	625	43.9%
	Never	530	37.2%
	NR	200	14.0%
		1424	
Q18j	Electronic prescription service		
	Regularly	563	39.5%
	Sometimes	145	10.2%
	Never	525	36.9%
	NR	191	13.4%
		1424	
Q18k	Emergency contraception service		
	Regularly	11	0.8%
	Sometimes	26	1.8%
	Never	1053	73.9%
	NR	334	23.5%
		1424	
Q18l	Falls prevention		
	Regularly	8	0.6%
	Sometimes	17	1.2%
	Never	1065	74.8%
	NR	334	23.5%
		1424	
Q18m	Flu vaccination services		
	Regularly	98	6.9%
	Sometimes	126	8.8%
	Never	907	63.7%
	NR	293	20.6%
		1424	
Q18n	Handing in prescription for medication (dispensing)		
	Regularly	495	34.8%
	Sometimes	548	38.5%
	Never	212	14.9%
	NR	169	11.9%
		1424	
Q18o	Headlice Service		
	Regularly	7	0.5%
	Sometimes	29	2.0%
	Never	1049	73.7%
	NR	339	23.8%
		1424	
Q18p	Health and Medicines advice		
	Regularly	87	6.1%
	Sometimes	571	40.1%
	Never	500	35.1%
	NR	266	18.7%
		1424	

Q18q	Health checks services		
	Regularly	40	2.8%
	Sometimes	120	8.4%
	Never	946	66.4%
	NR	318	22.3%
		1424	
Q18r	Healthy weight advice		
	Regularly	16	1.1%
	Sometimes	34	2.4%
	Never	1038	72.9%
	NR	336	23.6%
		1424	
Q18s	Inhaler technique service		
	Regularly	15	1.1%
	Sometimes	55	3.9%
	Never	1020	71.6%
	NR	334	23.5%
		1424	
Q18t	Long term condition advice		
	Regularly	38	2.7%
	Sometimes	93	6.5%
	Never	969	68.0%
	NR	324	22.8%
		1424	
Q18u	Medicine use reviews		
	Regularly	81	5.7%
	Sometimes	216	15.2%
	Never	837	58.8%
	NR	290	20.4%
		1424	
Q18v	Minor ailment scheme		
	Regularly	30	2.1%
	Sometimes	122	8.6%
	Never	950	66.7%
	NR	322	22.6%
		1424	
Q18w	Needle exchange service		
	Regularly	8	0.6%
	Sometimes	4	0.3%
	Never	1071	75.2%
	NR	341	23.9%
		1424	
Q18x	Pregnancy testing		
	Regularly	8	0.6%
	Sometimes	9	0.6%
	Never	1063	74.6%
	NR	344	24.2%
		1424	
Q18y	Prescription collection service		
	Regularly	570	40.0%
	Sometimes	218	15.3%
	Never	451	31.7%
	NR	185	13.0%
		1424	
Q18z	Prescription delivery service		
	Regularly	151	10.6%
	Sometimes	109	7.7%
	Never	866	60.8%
	NR	298	20.9%
		1424	

Q18aa	Repeat prescriptions		
	Regularly	815	57.2%
	Sometimes	174	12.2%
	Never	314	22.1%
	NR	121	8.5%
		1424	
Q18ab	Supervised consumption service		
	Regularly	4	0.3%
	Sometimes	9	0.6%
	Never	1064	74.7%
	NR	347	24.4%
		1424	
Q18ac	Stop smoking advice		
	Regularly	6	0.4%
	Sometimes	14	1.0%
	Never	1064	74.7%
	NR	340	23.9%
		1424	
Q19	Overall, are you happy with the services that your local (or usual) pharmacy provides?		
	Yes	1347	94.6%
	No	56	3.9%
	NR	21	1.5%
		1424	
Q19a	If no, please provide details below		
	Responses Received	54	96.4%
	NR	2	3.6%
		56	
Q20	Are there any other services which are not available but you would like a pharmacy to provide?		
	Yes	82	5.8%
	No	1272	89.3%
	NR	70	4.9%
		1424	
Q20a	If yes, please specify		
	Responses Received	76	92.7%
	NR	6	7.3%
		82	
Q21	If there is anything else you would like to tell us about pharmacies in your area, please do so below:		
	Responses Received	388	27.2%
	NR	1036	72.8%
		1424	

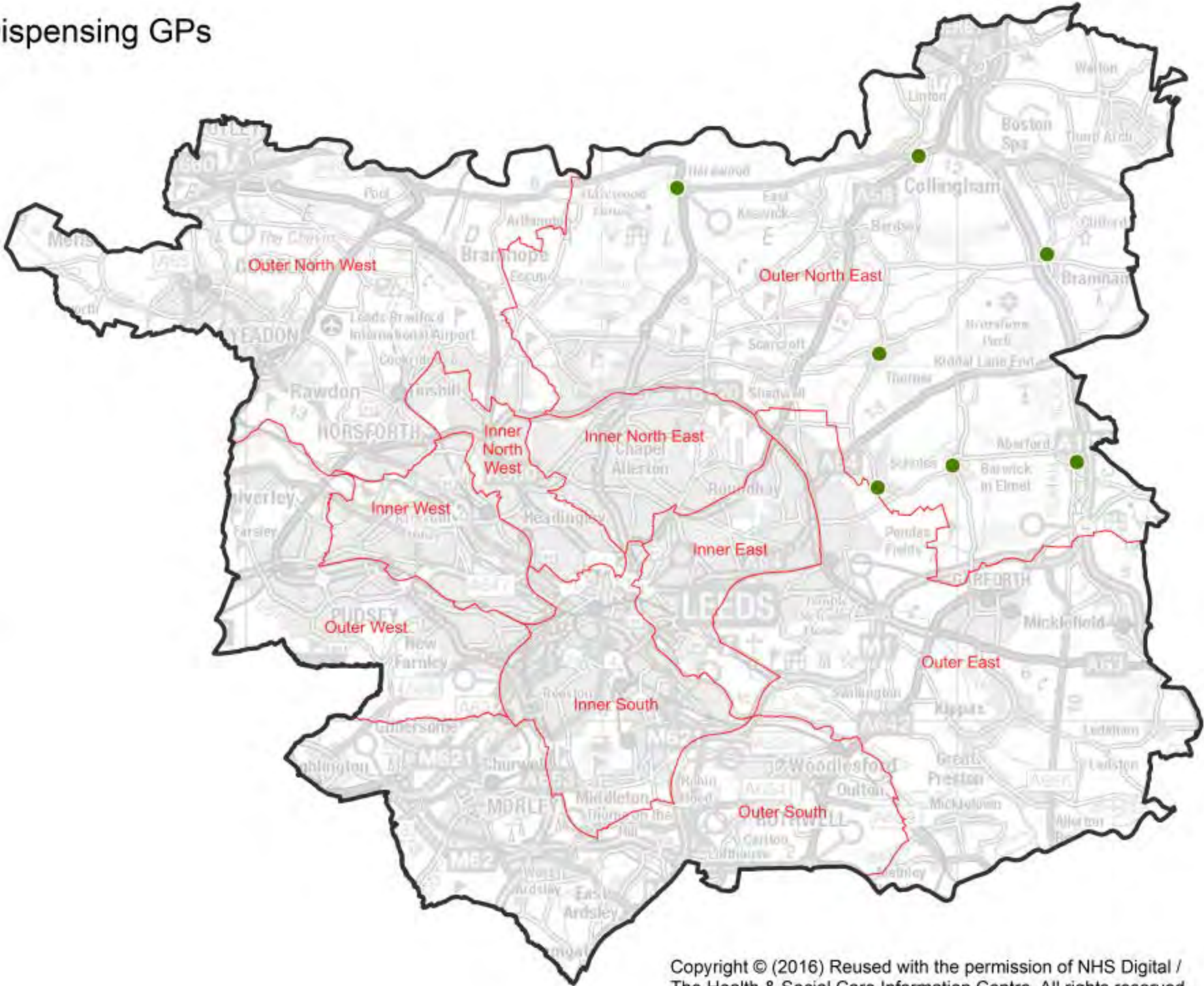
About You		
Q22	Which of the Leeds electoral wards do you live in?	
	Adel and Wharfedale	215 15.1%
	Alwoodley	55 3.9%
	Ardsley and Robin Hood	15 1.1%
	Armley	27 1.9%
	Beeston and Holbeck	22 1.5%
	Bramley and Stanningley	53 3.7%
	Burmantofts and Richmond Hill	21 1.5%
	Calverley and Farsley	25 1.8%
	Chapel Allerton	60 4.2%
	City and Hunslet	31 2.2%
	Cross Gates and Whinmoor	43 3.0%
	Farnley and Wortley	39 2.7%
	Garforth and Swillington	54 3.8%
	Gipton and Harehills	20 1.4%
	Guiseley and Rawdon	30 2.1%
	Harewood	20 1.4%
	Headingley	24 1.7%
	Horsforth	41 2.9%
	Hyde Park and Woodhouse	11 0.8%
	Killingbeck and Seacroft	22 1.5%
	Kippax and Methley	19 1.3%
	Kirkstall	24 1.7%
	Middleton Park	23 1.6%
	Moortown	46 3.2%
	Morley North	28 2.0%
	Morley South	47 3.3%
	Otley and Yeadon	49 3.4%
	Pudsey	67 4.7%
	Rothwell	29 2.0%
	Roundhay	64 4.5%
	Temple Newsam	48 3.4%
	Weetwood	28 2.0%
	Wetherby	59 4.1%
	Don't know	36 2.5%
	NR	29 2.0%
		1424
Q23	What is the postcode for your home?	
	Responses Received	1320 92.7%
	NR	104 7.3%
		1424
Q24	What is your gender?	
	Male	671 47.1%
	Female	728 51.1%
	Trans Male	2 0.1%
	Trans Female	1 0.1%
	Gender non-binary	0 0.0%
	Other	2 0.1%
	NR	20 1.4%
		1424
Q24a	If other, please specify	
	Responses Received	0 0.0%
	NR	2 100.0%
		2
Q25	Is your gender the same as that which was assigned at birth?	
	Yes	1381 97.0%
	No	2 0.1%
	NR	41 2.9%
		1424
Q26	How old are you?	
	Under 18	18 1.3%
	18 - 29	23 1.6%
	30 - 44	162 11.4%
	45 - 64	521 36.6%
	65 +	676 47.5%
	NR	24 1.7%
		1424

Q27	What is your sexual orientation?		
	Heterosexual (straight)	1226	86.1%
	Lesbian (gay woman)	13	0.9%
	Gay man	33	2.3%
	Bisexual	13	0.9%
	Prefer not to say	75	5.3%
	NR	64	4.5%
		1424	
Q28	What is your ethnic group? Tick the one option which best describes your ethnic group or background.		
	White - English / Welsh / Scottish / Northern Irish / British	1260	88.5%
	White - Irish	14	1.0%
	White - Gypsy or Irish Traveller	1	0.1%
	White - Any other White background	24	1.7%
	Mixed - White and Black Caribbean	4	0.3%
	Mixed - White and Black African	3	0.2%
	Mixed - White and Asian	8	0.6%
	Mixed - Any other Mixed / multiple ethnic background	5	0.4%
	Asian - Indian	19	1.3%
	Asian - Pakistani	5	0.4%
	Asian - Bangladeshi	4	0.3%
	Asian - Kashmiri	3	0.2%
	Asian - Chinese	2	0.1%
	Asian - Any other Asian background	1	0.1%
	Black - African	11	0.8%
	Black - Caribbean	9	0.6%
	Black - Any other Black background	0	0.0%
	Other - Arab	0	0.0%
	Other - Any other background	9	0.6%
	NR	42	2.9%
		1424	
Q29	What is your religion or belief?		
	No religion	441	31.0%
	Christian	824	57.9%
	Buddhist	10	0.7%
	Hindu	8	0.6%
	Jewish	17	1.2%
	Muslim	17	1.2%
	Sikh	8	0.6%
	Other	34	2.4%
	NR	65	4.6%
		1424	
Q29a	If other, please specify		
	Responses Received	27	79.4%
	NR	7	20.6%
		34	
Q30	Do you practice your religion or belief?		
	Yes	526	36.9%
	No	751	52.7%
	NR	147	10.3%
		1424	
Q31	Do you consider yourself to have a disability or long term illness / health problem?		
	Yes	531	37.3%
	No	862	60.5%
	NR	31	2.2%
		1424	
Q32	If yes, how would you describe your type of disability?		
Q32:1	Physical disability (like needing a wheelchair to get around, difficulty using your arms)	153	23.6%
Q32:2	Sensory disability	20	3.1%
Q32:3	Sensory disability (like being blind or partially sighted or hearing loss)	64	9.9%
Q32:4	Mental health problem (like depression or schizophrenia)	76	11.7%
Q32:5	Learning disability (like Down's syndrome or autism)	4	0.6%
Q32:6	Long standing illness or health problem (like cancer, HIV, diabetes, epilepsy)	330	51.0%
		647	

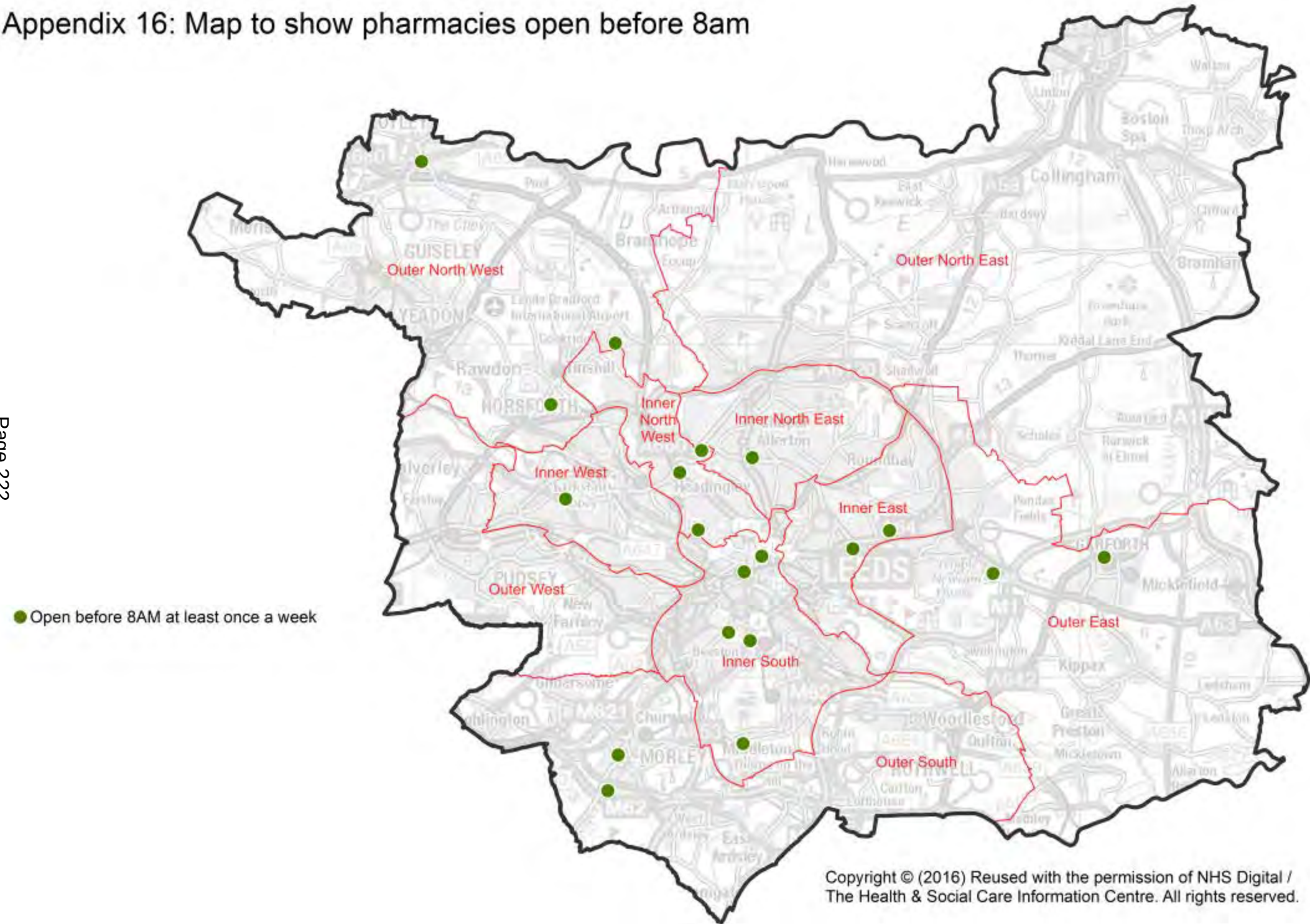
Q33	Do you consider yourself to be a carer?		
	Yes	229	16.1%
	No	1152	80.9%
	NR	43	3.0%
		1424	
Q34	If you or someone you care for is disabled, have any adjustments been made to help with medicines (e.g. medication reminder charts, large print labels, non-stick tops)?		
	Yes	90	6.3%
	No	288	20.2%
	Not applicable	955	67.1%
	NR	91	6.4%
		1424	

Appendix 15: Dispensing GPs

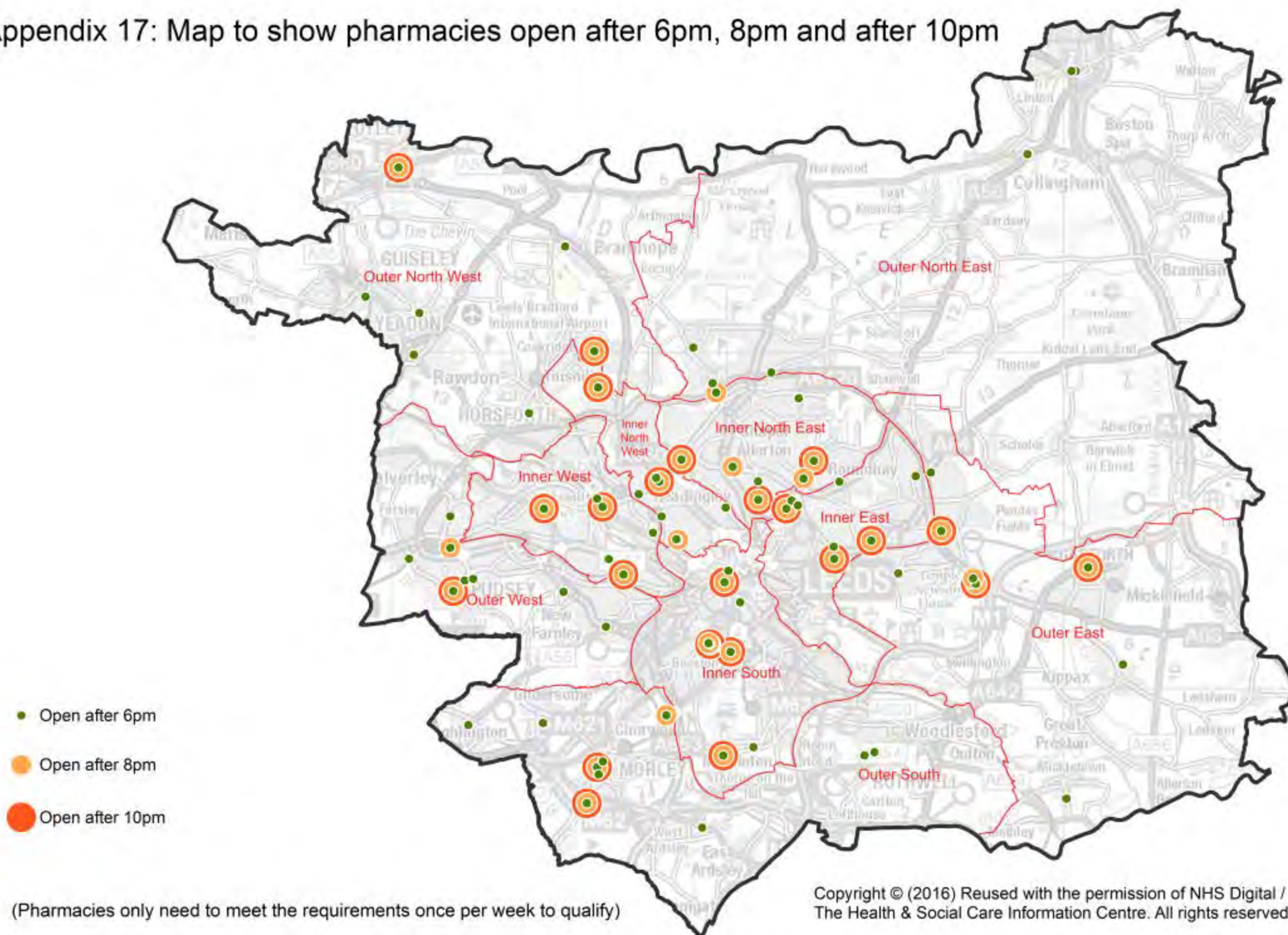
● Dispensing GPs



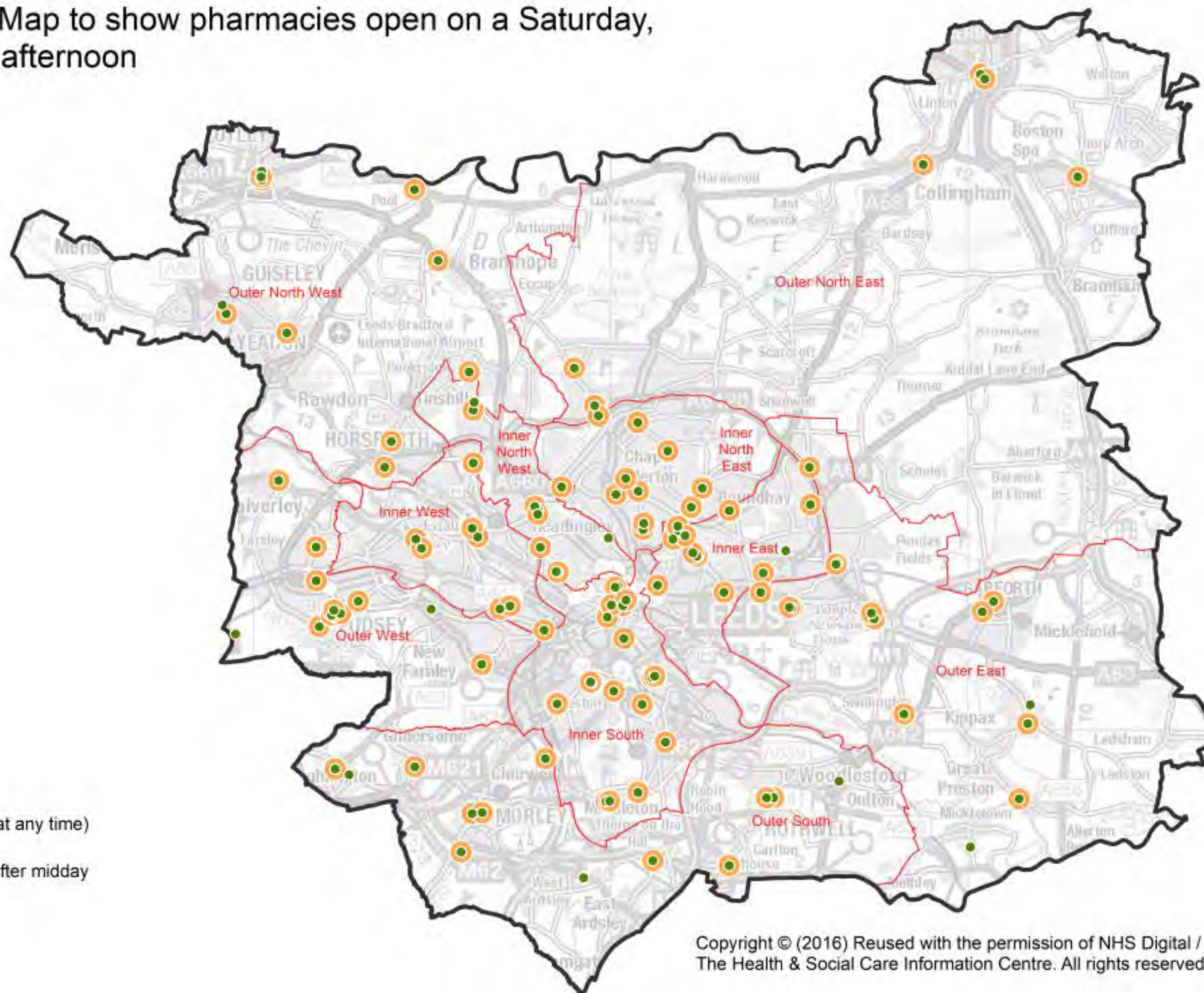
Appendix 16: Map to show pharmacies open before 8am



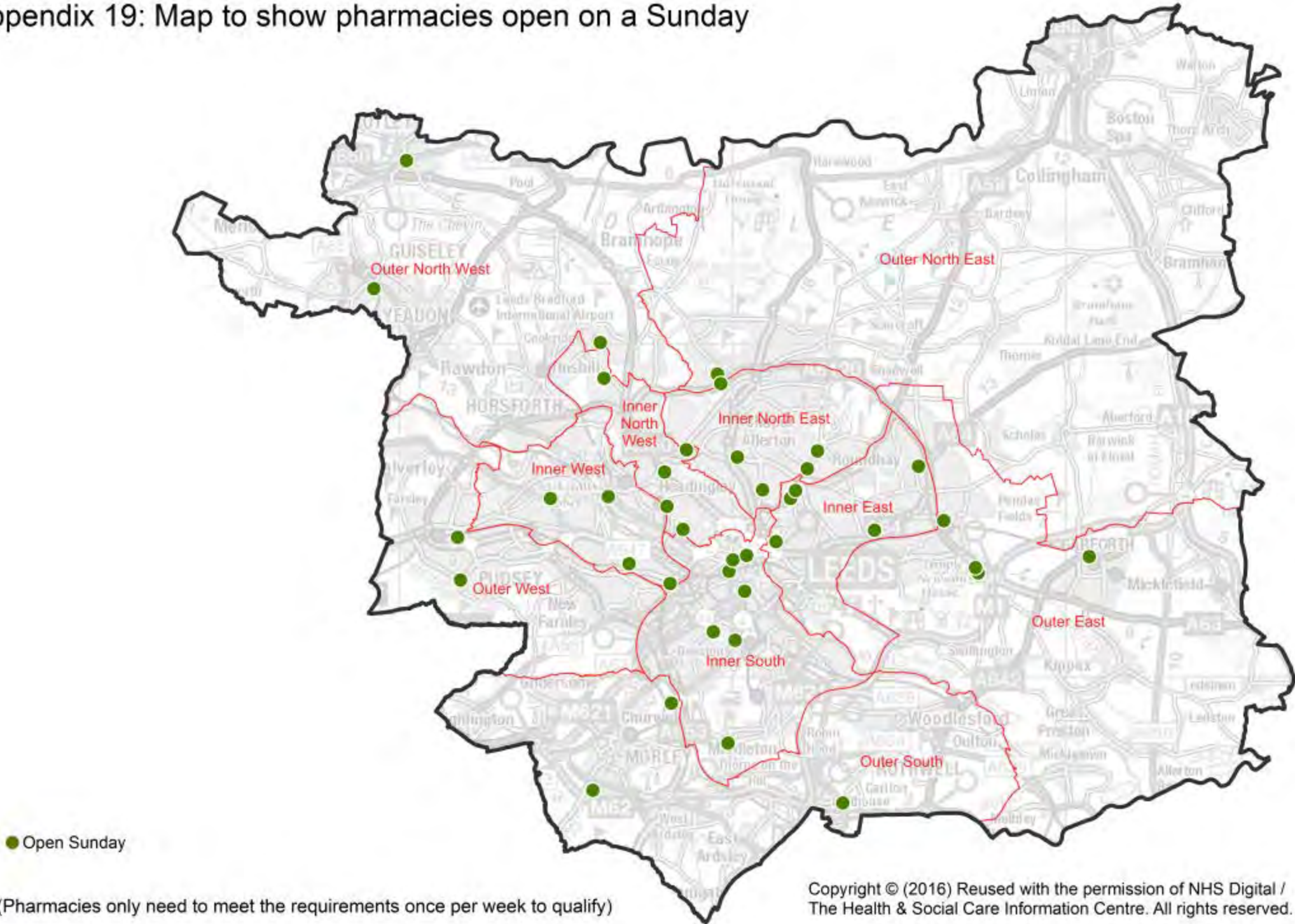
Appendix 17: Map to show pharmacies open after 6pm, 8pm and after 10pm



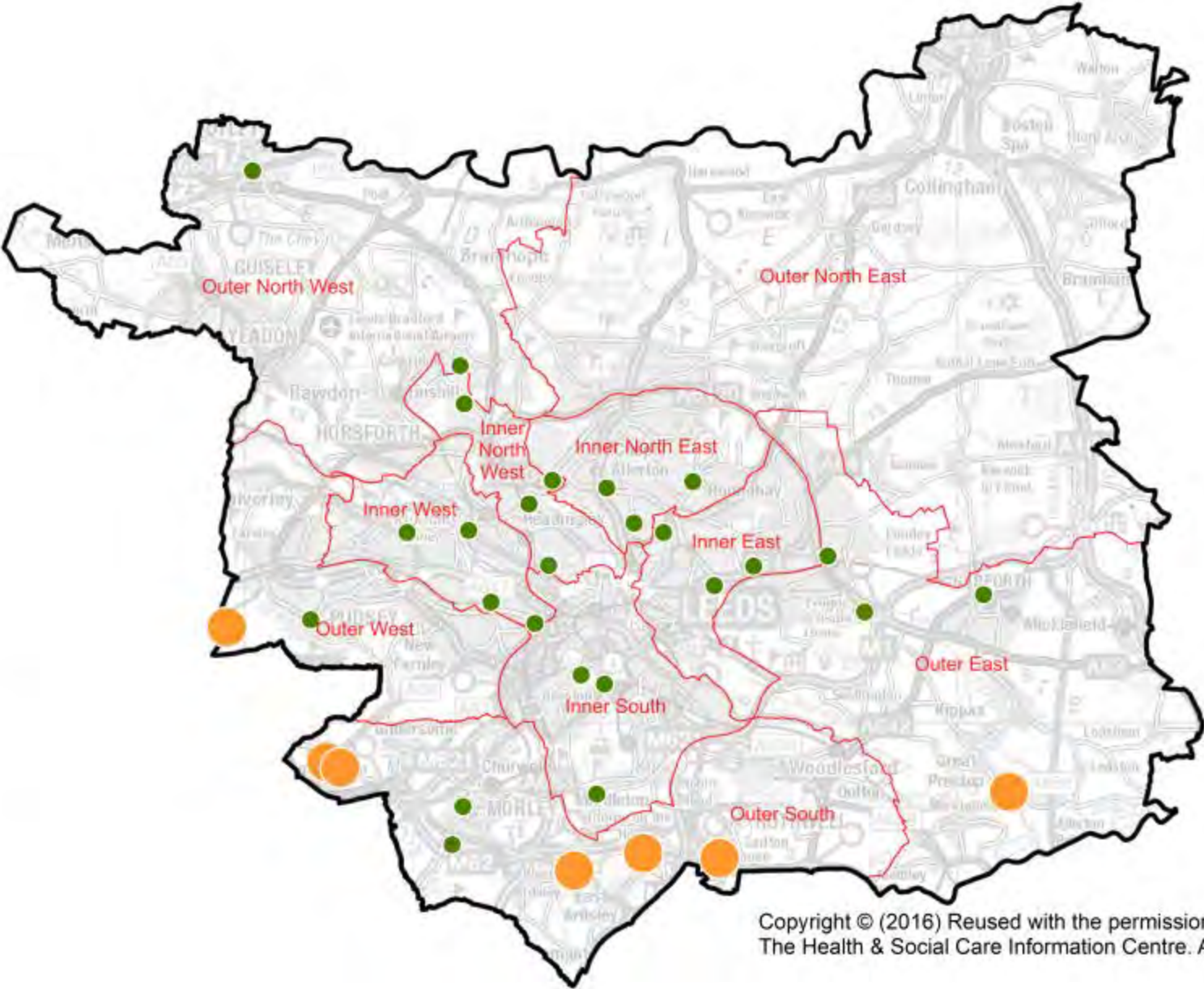
Appendix 18: Map to show pharmacies open on a Saturday, and Saturday afternoon



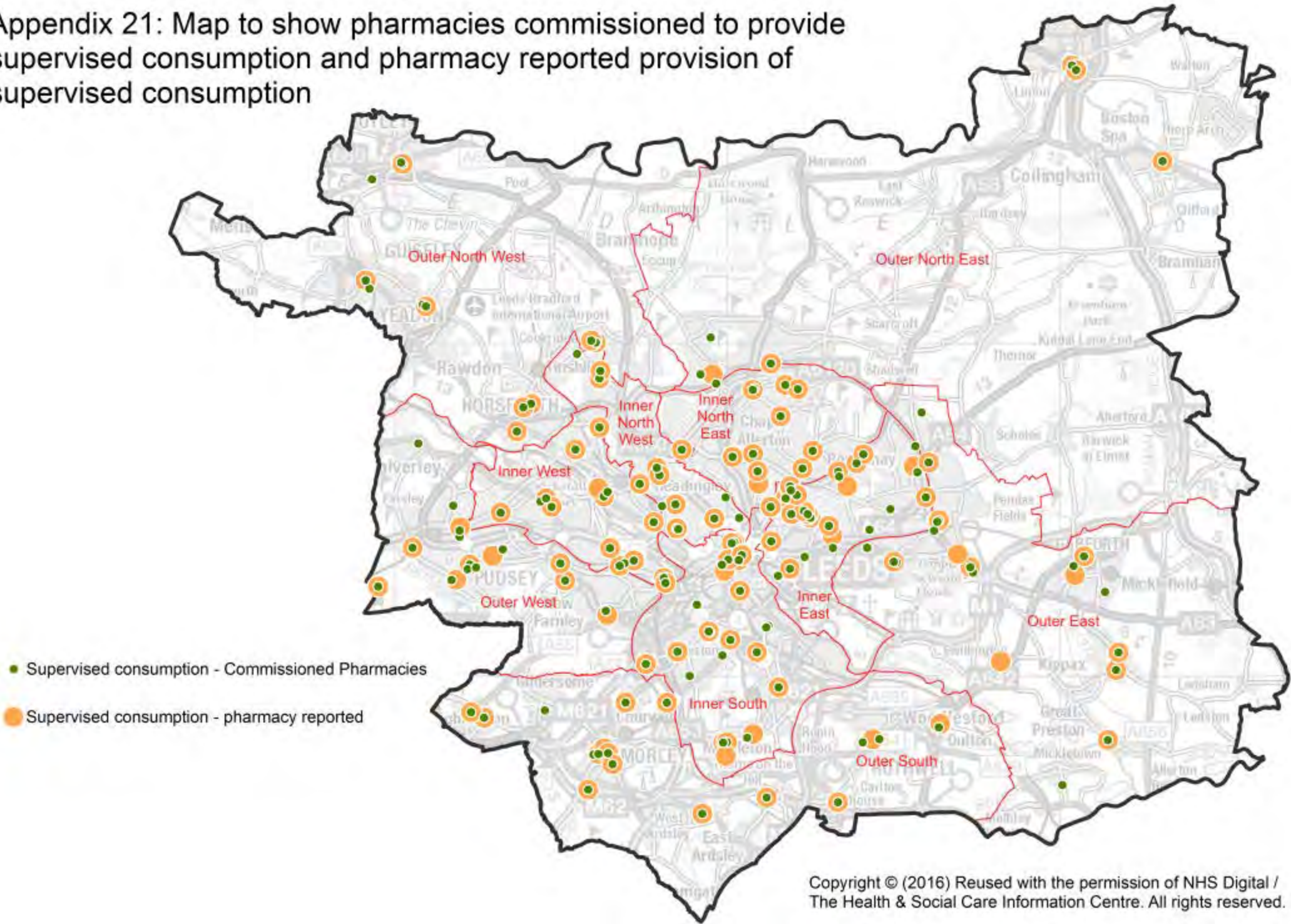
Appendix 19: Map to show pharmacies open on a Sunday



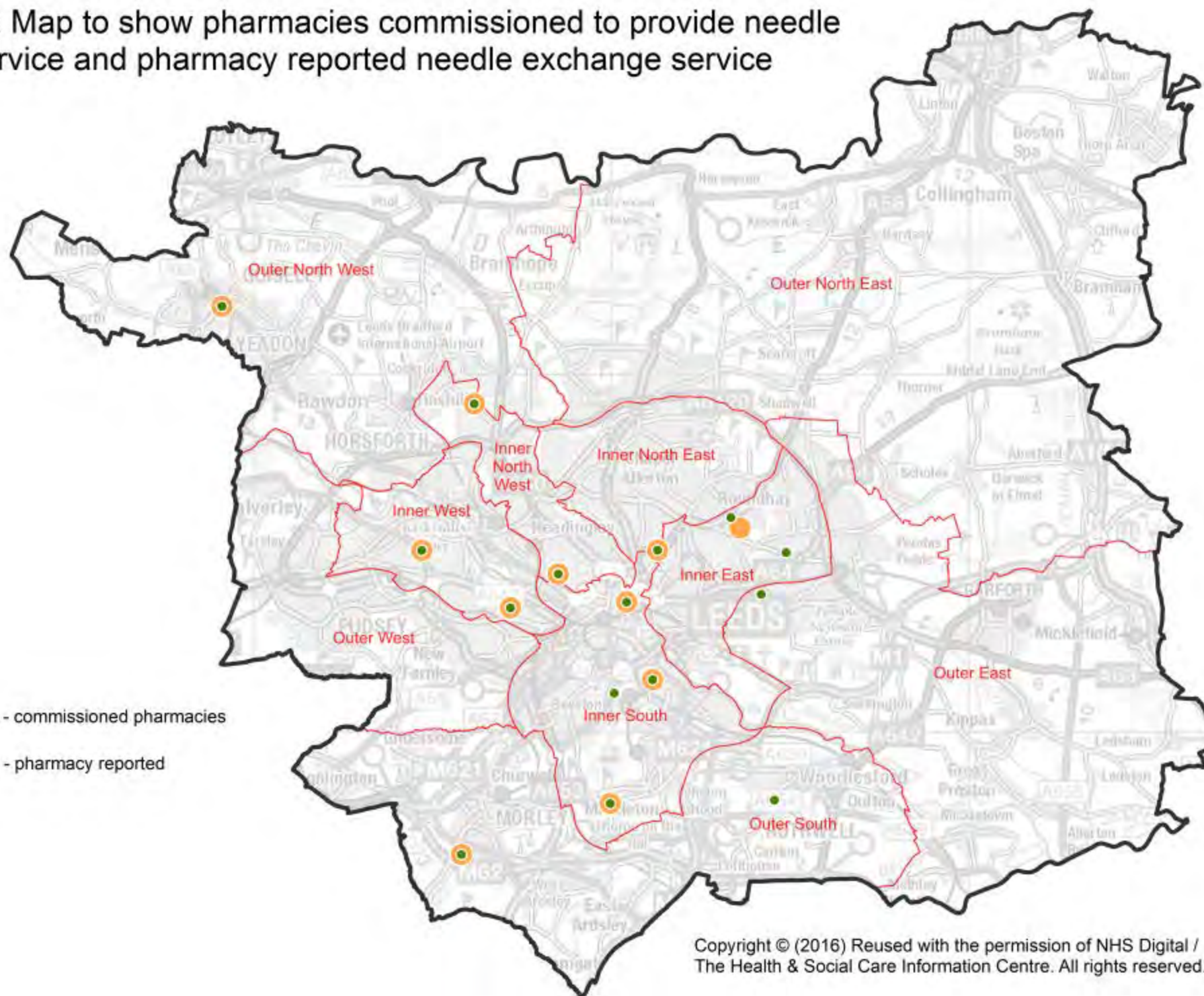
Appendix 20: 100 hour pharmacies commissioned by NHS England



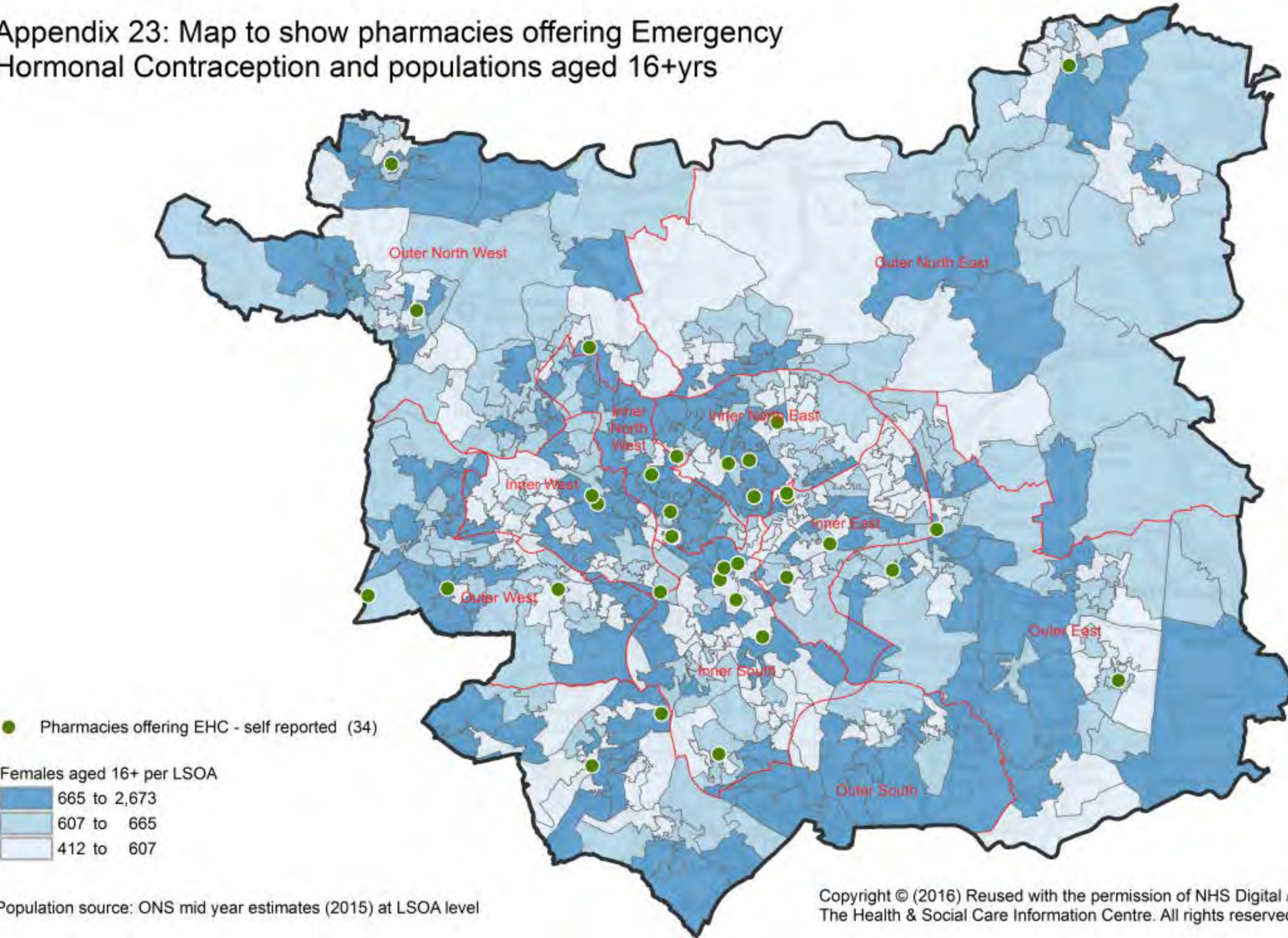
Appendix 21: Map to show pharmacies commissioned to provide supervised consumption and pharmacy reported provision of supervised consumption



Appendix 22: Map to show pharmacies commissioned to provide needle exchange service and pharmacy reported needle exchange service



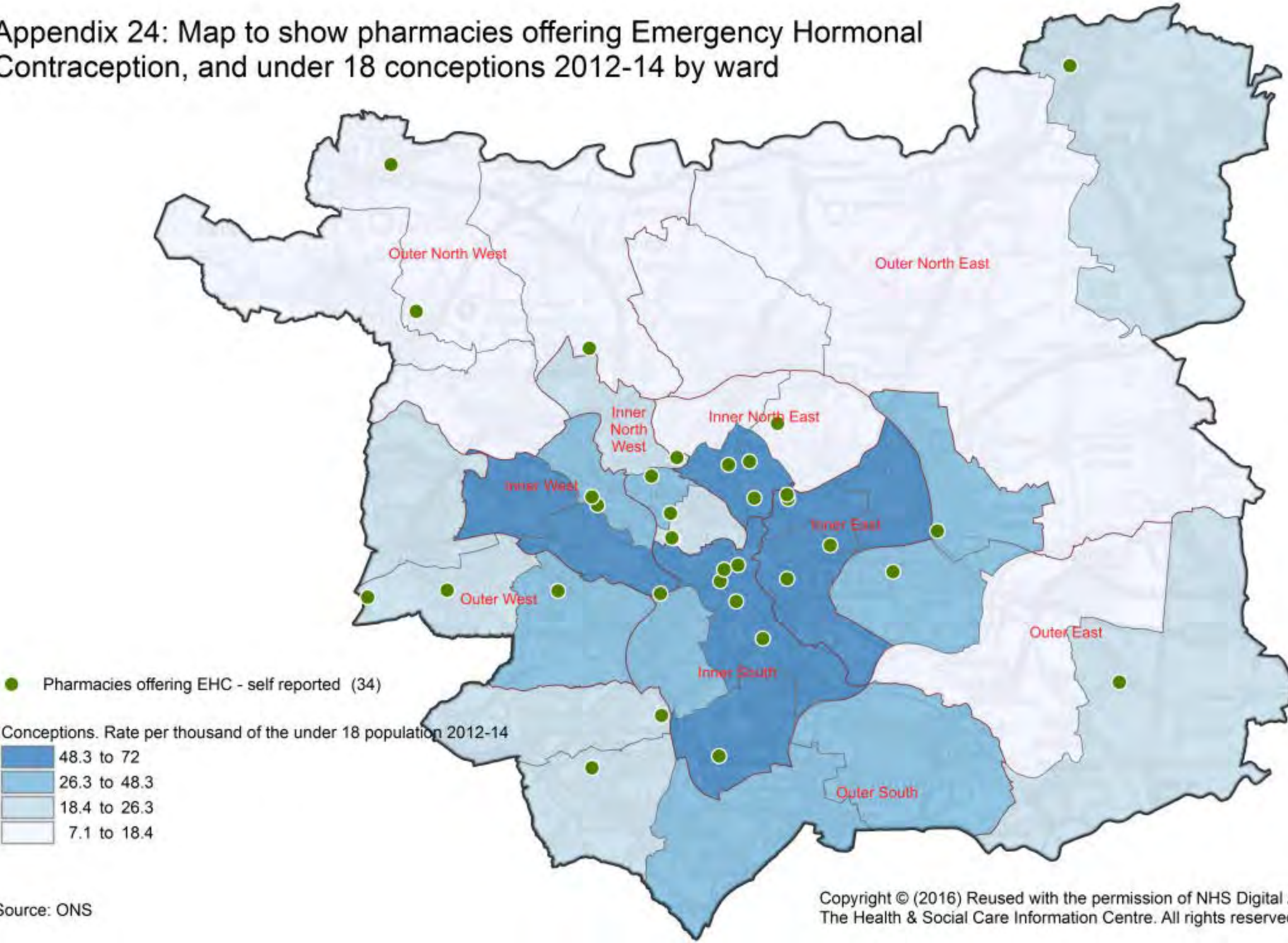
Appendix 23: Map to show pharmacies offering Emergency Hormonal Contraception and populations aged 16+ yrs



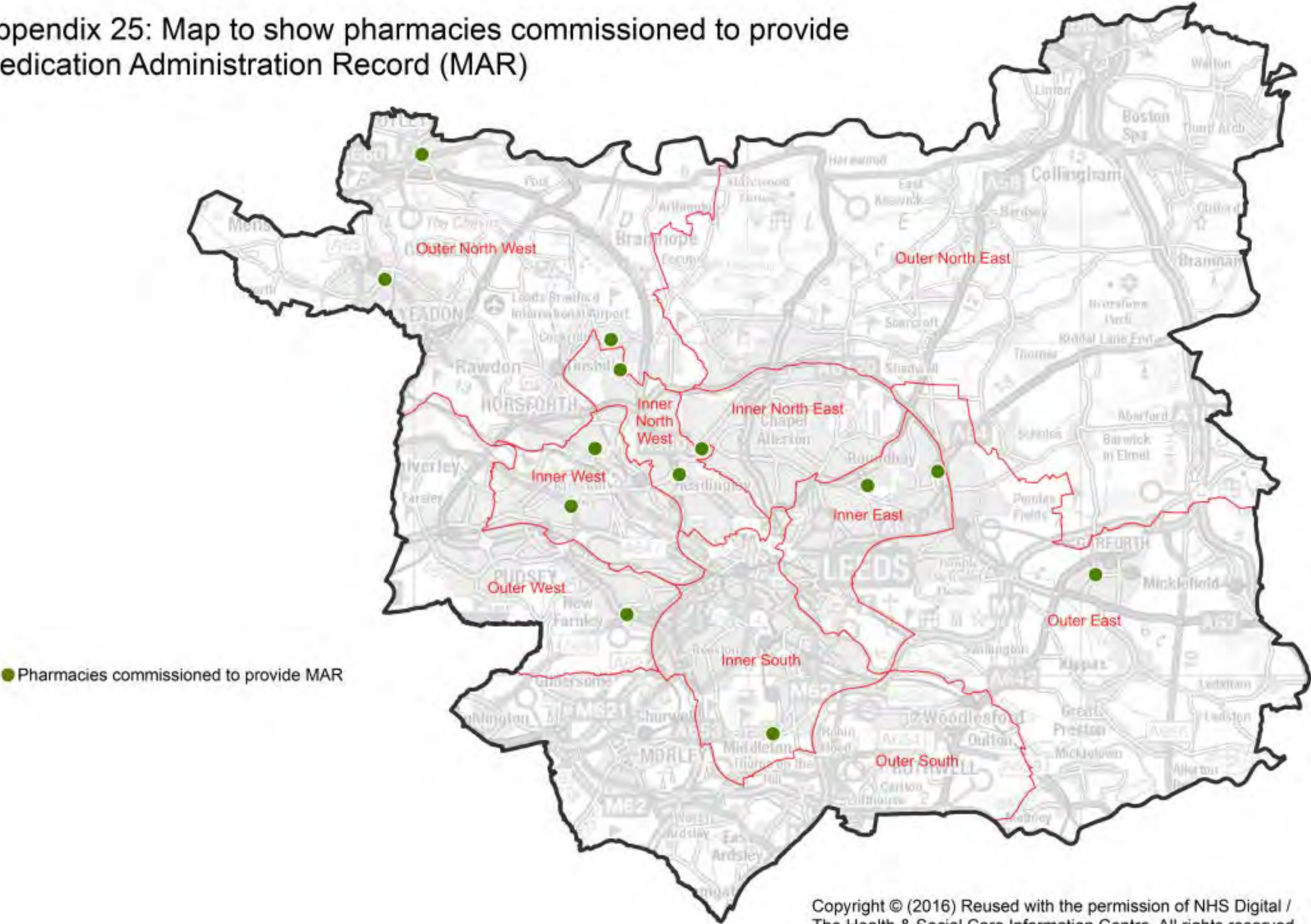
Population source: ONS mid year estimates (2015) at LSOA level

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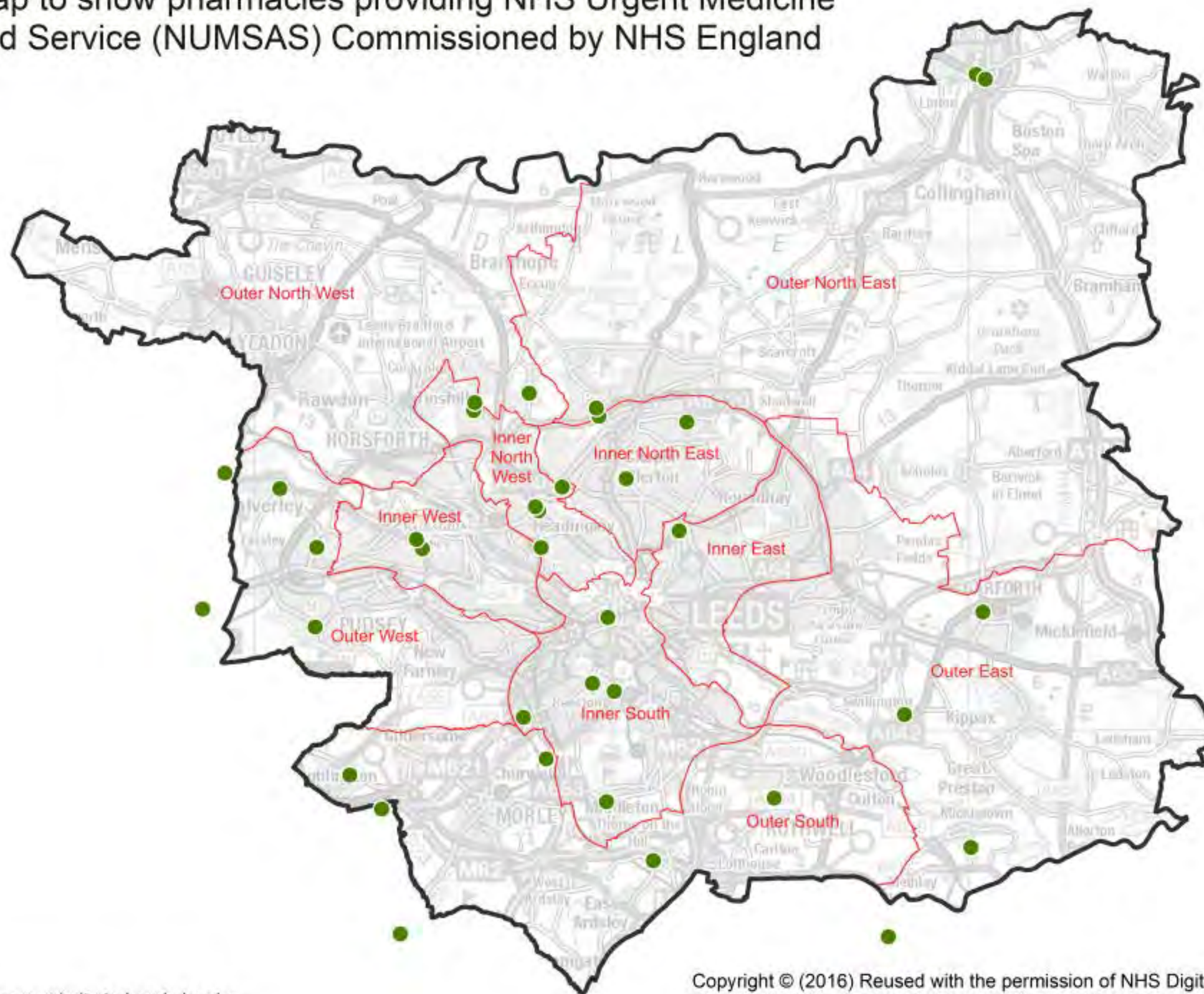
Appendix 24: Map to show pharmacies offering Emergency Hormonal Contraception, and under 18 conceptions 2012-14 by ward



Appendix 25: Map to show pharmacies commissioned to provide Medication Administration Record (MAR)



Appendix 26: Map to show pharmacies providing NHS Urgent Medicine Supply Advanced Service (NUMSAS) Commissioned by NHS England



Leeds City Council PNA Stakeholder Feedback from 60 day consultation period

Appendix 27.

Who	What	Outcome	Date received
Pharm-Assist (Healthcare) Ltd	Table 11 – seems to be an error. I can't imagine that 157 pharmacies are open after 8pm.	Agreed error-corrected	9-01-18
Leeds Community Healthcare NHS Trust (LCH):	Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes. The draft PNA is very comprehensive. Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes. Significant detail is provided in the draft PNA. Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones? Yes. Access to the minor ailment scheme and the development of an agreed palliative care scheme are of particular relevance to LCH.	Noted Noted Noted	17-01-18

Who	What	Outcome	Date received
LCH	Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? Nothing noted.	Noted	
Community Pharmacy West Yorkshire (CPWY)	In general Agree Leeds has excellent spread of pharmaceutical services and very good access to pharmaceutical services Encouraged that respondents expressed no concerns about current number, location and choice of pharmacies across city. Agree sufficient pharmacies and no gaps in necessary provision nor gaps where further services would result in better access to pharmaceutical services.	Noted	19-01-18
CPWY	How assessment was carried out. Confident points taken into account, but not explained clearly enough-how assessment was carried out, in particular how localities determined and different needs in localities, how it has taken into account different needs of people who share a protected characteristic.	Updated document	19-01-18
CPWY	Gaps Draft PNA not explicit enough when explaining position taken on gaps in provision- CPW suggested sentiment of PNA summarised by: "There are no current gaps in the provision of necessary services in the area of the Health and Wellbeing Board"	Wording amended as suggested to aid clarity. Added 'related' commissioning intentions as HWB does not commission services	19-01-18

Who	What	Outcome	Date received
CPWY	“There are no current gaps in the provision of other relevant services in the area of the Health and Wellbeing Board” The PNA has not identified any future needs which could not be met by pharmacies already currently on the pharmaceutical list, which would form part of its commissioning intentions.		
CPWY	Regulation 9(1) CPWY also believes all areas of Leeds have a reasonable choice of pharmaceutical services and we are not aware of a body of stakeholder views to the contrary. The intention of the PNA seems to be in agreement that this is the case and the sentiment of the draft PNA could be summarised with the following statement which we would suggest should be added to the final version to help meet Regulation 9(1)(b). Regulation 9(2) ☐ We are not aware of any expected significant changes to demography, population size or changes to the health or wellbeing in the area which would mean, within the life of this PNA, that there would be a future need for additional pharmaceutical services for which there is a planned intention to commission. If this is supported by the PNA we would recommend including a statement to the following effect: ☐	Added “There is a reasonable and adequate choice of pharmacies and pharmaceutical services in all areas of Leeds” where appropriate	19-01-18

Who	What	Outcome	Date received
CPWY	“The PNA, having regard to likely changes to the number of people requiring pharmaceutical services, the demography of the area and the risks to the health and wellbeing of people in the area, has not identified any future needs which are not already met by providers currently on the pharmaceutical list”	Added where appropriate	
CPWY	Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes, The PNA contains relevant information about the health and pharmaceutical needs of the population. Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes. The PNA has taken into account likely changes in numbers of the population requiring pharmaceutical services, the demographics of the city, and health and wellbeing in the Leeds City Council area which has enabled likely future needs over the next 3 years to be identified.	Noted Noted	19-01-18

Who	What	Outcome	Date received
CPWY	Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones? The PNA does not identify any service gaps. It is recommended that the PNA clearly outlines this conclusion (see response above as to how the PNA 3 could be improved in line with the regulatory requirements.). Further clarity may be achieved by including a summary / conclusion at the beginning of the PNA. Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? Information on which the PNA is based The PNA must clearly state that the date that on which the information included within it was correct. Section 1.3 Opening times The PNA would benefit from a description of pharmacies open in the weekday evening and Sundays.	Noted and amended to aid further clarity 1st January 2018 added Added	19-01-18

Who	What	Outcome	Date received
CPWY	It is noted that the draft PNA does describe Saturday opening in section 1.3 and overall opening in section 5.5. Merging of this information to make it clearer to the reader of the PNA should be considered.	Amended	19-01-18
CPWY	The draft PNA section 1.3 includes information on access to pharmaceutical services. This information may benefit from a separate section. It should be made clear that being more than 1 mile away from a pharmacy does not create a gap in provision nor mean that a patient 'struggles' to access pharmaceutical services. There was no evidence to suggest that the current provision is not good and the future plans of Leeds Council to improve public transport will only improve the currently good access.	Noted-amended	19-01-18
CPWY	University population Leeds is a university city with 2 universities and several campus sites across the city. As such there will be an influx (both on a daily and term-time basis) of (mainly young) people. The requirements of this cohort of population should be noted within the PNA. This need is met by the current pharmaceutical provision but this should be captured within the PNA. Consideration may also be needed for college / post-16 education sites which draw in numbers of non-Leeds resident students on a daily-basis.	Added further information in protected characteristics section under age	19-01-18

Who	What	Outcome	Date received
CPWY	Points of accuracy 1.1 Access and geographical coverage This section states: The Outer North East area has fewer community pharmacists but there are now four dispensing GPs in this area and seven distance-selling pharmacies across Leeds. This means there are no geographical gaps in provision The word 'now' should be removed as the dispensing GPs were in place when the previous PNA was written	Amended. Also, all dispensing GPs fall into this Community Committee area	19-01-18
CPWY	1.2 Services provided The draft PNA includes Healthy Living Pharmacy (HLP) as the only service listed under section 1.2. HLP is not a service, but a quality mark of a pharmacies achievement against a defined framework. Information regarding HLPs should be moved to another section of the PNA Services.	Amended.	19-01-18
CPWY	1.7 2 Newly-emerging communities Equality and diversity training is not a requirement for community pharmacy and therefore not relevant to a pharmaceutical needs assessment. Pharmacy has demonstrated through is adapted offer to patients with a disability / patients whose first language is not English / Gypsy travellers that it can, and does adapt their services to make them more accessible for the populations that they service. It is therefore unfounded to state it is possible that some newly emerging communities experience limitations of access to pharmacy services where there is no evidence for this and other information suggests that	E & D training not a requirement but would be measure of good practice and would enhance offer to everyone, but especially diverse community of Leeds. Agree PNA shows community pharmacies adapt well, but views of non-English speaking individuals and LGBT individuals were not fully captured in the PNA. Alternative form of wording agreed which acknowledges the	19-01-18

Who	What	Outcome	Date received
	pharmacy adapts its offer to meet the needs of patients. Completion of specified training is not linked to accessibility of a service; non-completion of a specified training does not mean that a service cannot and does not adapt to improve accessibility. The inclusion of equality and diversity training must be removed.	skills of pharmacy staff, but encourages everyone to expand skills as appropriate.	19-01-18
CPWY	Supporting primary care and public health 2015-2018 The draft PNA states that: the majority of NHS income for community pharmacies in England comes from payment from NHS England, through the NHS pharmaceutical services contract. This should be amended to state that the majority (90-95%) of total pharmacy income comes from payment from NHS England, through the NHS pharmaceutical services contract.	Amended	19-01-18
CPWY	The Pharmacy Access Scheme is currently for 2017/18 only. The draft PNA should be amended to reflect this.	Amended	19-01-18
	1.13 Changes to community pharmacy funding The 2017/18 funding cut was a 7.4% reduction not 3.4% as stated in the draft PNA.	Amended	19-01-18
CPWY	Figure 1 appears to show 7 dispensing GP practices where earlier in the PNA it was stated that there were 4 dispensing GPs. Only the GP branches where dispensing occurs should be marked on the map.	Amended-all seven dispense in Outer North East Community Committee Area	19-01-18

Who	What	Outcome	Date received
	Figure 1. This should be amended to LPS pharmacy as an individual contractor should not be named.	Amended	19-01-18
CPWY	Distance-selling pharmacies (DSP) cannot provide face-to-face essential services. It therefore may be misleading to mark DSPs on the maps in the same way as a bricks and mortar pharmacy as patients cannot access their services from the DSP physical location. It is suggested that DSPs are marked using a different shape / colour to distinguish them from other community pharmacies	Amended	19-01-18
CPWY	Distance-selling pharmacies DSPs cannot provide face to face essential services (but some other services can be provided face to face). The draft PNA should be amended to reflect this	Noted and amended	19-01-18
CPWY	3.4 Healthy Living Pharmacies (HLPs) There has been a significant growth in the number of Healthy Living Pharmacies (HLP) over the past 12 months. The number of Healthy Living Pharmacies is set to rapidly increase by November 2017. The final published PNA should include updated figures of the number of HLP pharmacies. Currently there are 112 HLPs within the Leeds Health and Wellbeing Board area.	Number increased to 149 between survey taking place and update Jan 2018. Added to PNA	19-01-18
CPWY	3.8 Types of pharmaceutical provider In Leeds, the Essential Small Pharmacies LPS contracts were all transferred to an LPS contract. Essential Small Pharmacy LPS no longer exist. The draft PNA should be amended to reflect this.	Was included in 5.1 of consultation draft but amended to make clearer	19-01-18
CPWY	5.3 Dispensing appliance contractors The draft PNA states that there are four Dispensing Appliance Contractors (DAC) outside of Leeds. Whilst there are 3 DAC within West Yorkshire, patients are free to use	NHSE provided details of four DACS. Wording amended to show wider access	19-01-18

Who	What	Outcome	Date received
CPWY	any DAC within England so are likely to be accessing DACs outside of West Yorkshire. Nationally there are numerous DACs which can be found: https://www.nhs.uk/service-search/Pharmacies/AppliancePharmacies/A The PNA should be amended to reflect that use of DACs is unlikely to be geographically bound		19-01-18
CPWY	6.12 1 Health protection – national flu immunisation programme 2017/18 NHS England should be asked for the numbers of pharmacies in Leeds providing the NHS Flu vaccination service in 2017/18. These figures are available and would provide a more up-to-date analysis of service provision. It is understood that significantly more pharmacies offer the NHS flu service in 2017/18 than in 16/17.	Updated figures (134) added	19-01-18
CPWY	6.12 2 NHS Urgent Medicine Supply Advanced Service (NUMAS) The service acronym is NUMSAS not NUMAS. This error is repeated in several areas of the draft PNA, including the appendixes and should be amended.	Amended	19-01-18
CPWY	NHS England should be asked for the numbers of pharmacies in Leeds providing the NUMSAS service. These figures are available and would provide a more up-to-date analysis of service provision. In December 2018 there were 29 pharmacies providing NUMSAS in Leeds.	Updated figures mapped	19-01-18
CPWY	NUMSAS cannot be provided as a non-commissioned service and reference to this should be removed from the PNA. Emergency supply is a non-commissioned service and can be provided by any pharmacy.	Removed. Some pharmacies had self- reported they were providing this service. Maps amended to show commissioned services	19-01-18

Who	What	Outcome	Date received
CPWY	7.1 Recommendations The recommendations include: That the Health and Wellbeing Board can be satisfied that the population of Leeds currently has very good access to community pharmaceutical services. It is recommended that the word community is removed to be in-line with the regulatory wording of pharmaceutical services.	Removed	19-01-18
CPWY	The draft PNA states: That the Health and Wellbeing Board will monitor and note any significant changes to population numbers, demographic composition and housing plans, making revisions to this PNA if deemed necessary, in accordance with regulations. A PNA cannot be amended other than producing a supplementary statement or conducting a complete PNA to revise the assessment.	Noted and amended	19-01-18
	Supplementary statements can only be made about the provision of pharmaceutical services. They cannot be used to describe changes in the need for pharmaceutical services. The Health and Wellbeing Board is only required to consider a revised assessment if there is a significant change to the need for pharmaceutical services. This should be clarified in the final version of the PNA.	Noted and amended	19-01-18

Who	What	Outcome	Date received
CPWY	The draft PNA states: That existing pharmacy teams review their equality and diversity training to ensure that staff who are not trained can build this into their training programme. This will help them to provide a more inclusive service for the diverse population of Leeds. Equality and diversity training is not a requirement for community pharmacy, nor a pharmaceutical service, and therefore not relevant to a pharmaceutical needs assessment. It is recommended that this recommendation is removed from the PNA. As per previous comments completion, or not, of specified training cannot be linked to the ability of a pharmacy contractor, or not, to adapt their services to improve access.	E & D training not a requirement but is indication of good practice and would enhance offer to everyone but especially diverse community of Leeds. Agree PNA shows community pharmacies adapt well, but views of non-English speaking individuals and LGBT individuals were not fully captured in the PNA. Alternative form of wording agreed which acknowledges skills of pharmacy staff, but encourages everyone to expand skills as appropriate	19-01-18
Armley Pharmacy	Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years? Yes	Noted Noted	01-02-18

Who	What	Outcome	Date received
Armley Pharmacy	Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones?		01-02-18
	Yes	Noted	
	Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need?		
	N/A	Noted	
NHS England	Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds?		02-02-18
	Yes	Noted	
	Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years?		
	Yes	Noted	

Who	What	Outcome	Date
NHS England	Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones? No service gaps have been identified Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need? Shown below	Noted Noted	
NHS England	We are supportive of the overall content of the draft PNA and are in agreement with the main findings of the PNA in that there are no current gaps in the provision of pharmaceutical services in the Leeds Health and Well Being Board area and that no future needs have been identified which could not be met by pharmacies on the already on the pharmaceutical list. It is felt that a robust process has been undertaken to review the PNA which has included strong engagement with a wide list of stakeholders as well as actively seeking the views of Leeds citizens.	Noted	02-02-18
NHS England	We would like to note the following points of accuracy and suggested revisions on the draft PNA; Executive summary The executive summary is rather lengthy and contains a lot of information. Our suggestion	Noted and amended	02-02-18

Who	What	Outcome	Date
NHS England	would be that the executive summary is reviewed to present the main findings of the information collected in a more concise way making it clearer to the reader. In particular in relation to 1.1 Access and geographical coverage, the findings described need to be more definitive in explaining what is being concluded.	Noted and amended	02—02-18
NHS England	As a point of accuracy a PNA cannot be amended once published other than producing a supplementary statement or where for any significant changes it is deemed that a revised assessment is required Suggestion for the wording in sections 1.1 Executive Summary and 7.1 Recommendations are revised to acknowledge this.	Noted and amended	02-02-18
NHS England	1.13 Changes to community pharmacy funding In this section the draft PNA describes that: ‘Since the last PNA there have been significant funding cuts, which are now being implemented’. It is suggested is that the language used here is revised to replace the word ‘cut’ with ‘reduction’. Please find suggested revision below: <i>‘Since the last PNA there have been significant changes to the community pharmacy contractual framework. These changes are now being implemented and the impact of which is a reduction in the funding which community pharmacies receive’</i> Likewise on page 11, the draft PNA states that: “The community pharmacy survey did not show obvious evidence of these cuts being a barrier to the	Noted and amended	02-02-18

Who	What	Outcome	Date
NHS England	day-to-day functioning of community pharmacies in Leeds,” Again it is suggested that this wording is revised to: <i>‘The community pharmacy survey did not show obvious evidence of these reductions in funding being a barrier to the day-to-day functioning of community pharmacies in Leeds’</i>	Noted and amended	02-02-18
NHS England	1.7 2 Newly-emerging communities This section of the draft PNA reports that over half (58%) of responding pharmacies have no staff with Equality and Diversity training. NHS England would like to clarify that equality and diversity training is not a requirement for community pharmacy. In terms of the question asked it is felt that this could have been interpreted in a number of ways and that equality and diversity awareness can be raised via a number of routes and not only through formal training which was not captured in the survey questions. From the information collected there is not the evidence to suggest that there is a direct link between completion of equality and diversity training and access to pharmaceutical services. Equality and Diversity training is also included within the recommendations listed in Section 7.1, where the recommendation for existing	E & D training not a requirement but would be measure of good practice and would enhance offer to everyone but especially diverse community of Leeds. Agree PNA shows community pharmacies adapt well, but views of non-English speaking individuals and LGBT individuals were not fully captured in the PNA. Alternative form of wording agreed which acknowledges skills of pharmacy staff, but encourages everyone to expand skills as appropriate	02-02-18

Who	What	Outcome	Date
NHS England	pharmacy teams to review their equality and diversity training to ensure that staff who are not trained can build this into their training programme Whilst it is recognised that there is a need to understand the data and feedback collected during the process it is not felt to be relevant to include this recommendation within the PNA in terms of the purpose of the document		02-02-18
NHS England	1.9 Gypsy Travellers This section uses the term 'chemist' which is not used elsewhere in the document. Our suggestion would be review the use of word 'chemist' in terms of consistency of language throughout the document. It may be that there is a reason for the use of the term 'chemist' here but this isn't clear to the reader.	Chemist was the term used by Gypsy Travellers in the HNA referred to-amended to explain this in PNA	02-02-18
NHS England	2.1 Legislative requirements of the PNA This section in the draft PNA describes the primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list. Whilst this is accurate that the PNA supports NHS England to review applications, it is also worth reflecting that PNAs are used by both the NHS and Local Authorities when considering which services can be or need to be provided by community pharmacies. As a point of accuracy we ask that ' NHS England West Yorkshire team' is revised to NHS England. This is also consistent with the name used throughout the rest of the document.	Amended	02-02-18

Who	What	Outcome	Date
NHS England	3.3 New developments in GP and primary care services It is suggested that the following revisions be made to the wording within this section: Pg. 17 <i>GPs may need to join some of their practices work more collaboratively to share resources, staff and premises to make sure they can work in this new way. Other health, care and community services – and, potentially, community pharmacies – will need to join in with the approach.</i> <i>This big change would mean training the existing and future workforces to work with citizens and with each other in new ways.</i> Pg. 18 <i>The approach will bring some of the expertise of hospital doctors right into community services, which would mean less referrals into hospitals with to specialists and ensure that as much as possible being done in the community. This should mean fewer visits to hospital patients being able to access their care closer to home patients fewer procedures, but still be able to access the hospital services will still be there for when citizens they and their family need them.</i>	Amended where appropriate. Supplied by a colleague so reflected another perspective	02-02-18
NHS England	5.5 Opening times Table 11 Pharmacy opening times (October 2017) has one row labelled ‘Saturday’ and another ‘Saturday afternoon’. It is not clear here to the reader what is meant by ‘Saturday’ and how this differs from ‘Saturday afternoon’.	Amended to make clearer to reader	02-02-18

Who	What	Outcome	Date
NHS England	Section 1.3 Opening times (page 5) of the draft PNA states: <i>“A total of 126 pharmacies are open on Saturday. Of these, 111 are also open in the afternoon; 15 are open only on Saturday mornings.”</i> Again it is suggested is that the wording is made clearer here. The use of the word ‘only’ open on Saturday morning may also want to be considered as could be interpreted in a negative tone rather than a factual statement.	Amended to make clearer to reader	02-02-18
NHS England	NHS England would like to highlight to Leeds City Council the need for a timely and robust process for acknowledging and reviewing changes in relation to the provision of pharmaceutical services following notification from NHS England and that these are considered through the appropriate governance structures. In particular there needs to be a clear process for the assessment of changes to pharmaceutical provision which are deemed to require a supplementary statement and the approval of these	To be addressed outside of PNA	02-02-18
North Yorkshire County Council	Question 1: Do you think that the draft PNA captures all of the relevant information needed to identify gaps in pharmaceutical provision in Leeds? Yes, we acknowledge that a thorough process has been followed in liaising with, and seeking feedback from, the public, relevant parties and organisations during the production of the PNA and we confirm that we believe it meets the requirements as set out in the regulations.	Noted	

Who	What	Outcome	Date
North Yorkshire County Council	Question 2: Do you think that the draft PNA provides enough information to enable commissioning decisions about pharmaceutical service provision over the next 3 years?	Noted	01-02-18
	Yes, although it might be worth noting that access to pharmacies by residents living to the North of Leeds may be enhanced by provision in North Yorkshire (the towns of Harrogate, Tadcaster in the main). The North Yorkshire draft PNA has concluded that no changes are required to provision in these areas.	Noted	
	Question 3: Do you think that the service gaps that have been identified in the draft PNA are the right ones?	Noted	
	No gaps in service identified so yes		
	Question 4: Is there anything that you think is missing from the PNA that should be included or taken in to account when reaching conclusions about services and need?		
	No	Noted	

Leeds Health and Wellbeing Board



Report author: Shak Rafiq (NHS Leeds CCGs Partnership)

Report of: Shak Rafiq (Communications Manager, NHS Leeds Clinical Commissioning Groups Partnership)

Report to: Leeds Health and Wellbeing Board

Date: 19 February 2018

Subject: Progressing the NHS Leeds Clinical Commissioning Groups Partnership Annual Report 2017-2018

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

NHS England requires all NHS Clinical Commissioning Groups (CCGs) to produce annual reports in a prescribed format to a specific timescale.

One of the statutory requirements is for CCGs to review to what extent they have contributed to the local joint health and wellbeing strategy, to include this review in our annual reports and to consult with the Health and Wellbeing Board in preparing them.

This is the formal wording taking from NHS England's guidance *"Please review the extent to which the CCG has contributed to the delivery of any joint health and wellbeing strategy to which it was required to have regard under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007. It is a statutory requirement to include this review in your annual report and to consult with each relevant Health and Wellbeing Board in preparing it."*

In 2016-2017 we asked for the Health and Wellbeing Board to let us know if the content in each of the respective CCG annual reports closely reflected the work undertaken to contribute to the Leeds Health and Wellbeing Strategy 2016-2021 (Appendix 1). Feedback from the meeting demonstrated the need to bring this item to the Health and Wellbeing Board's attention sooner than the deadline date which last year allowed for only two working days for comments.

The three CCGs have been working as a formal partnership (NHS Leeds Clinical Commissioning Groups Partnership) and while we still need to produce three separate reports showing three sets of accounts we are able to produce a single narrative to demonstrate the CCG Partnership's achievements during 2016-2017.

We are asking for suggested contributions and an agreement on the key achievements that the CCG has supported in delivering the Leeds Health and Wellbeing Strategy 2016-2021. By bringing this item to the meeting for the 19 February 2018 meeting we have sufficient time available to ensure we have agreed content for the annual report by the draft copy deadline of 30 March 2018. This then gives CCG colleagues enough time to complete the entire draft report for submission to NHS England by midday on 20 April 2018.

Recommendations

The Health and Wellbeing Board is asked to:

- Support the process for developing the CCG annual report as outlined in para 3.6 to meet the statutory requirement outlined by NHS England.
- Acknowledge the extent to which the NHS Leeds CCGs have contributed to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021.
- Agree to the formal recording of this acknowledgement in the NHS Leeds CCGs' annual reports according to statutory requirement.

1 Purpose of this report

- 1.1 The purpose of this report is to provide an opportunity for members to agree on the key achievements of the Health and Wellbeing Board in delivering the Leeds Health and Wellbeing Strategy 2016-2021, with a particular reference on how the CCG has contributed to this.
- 1.2 Following feedback for this item from the meeting held on 20 April 2017, we have ensured that members of the Board have sufficient time to confirm the key achievements they would like included in the CCG's annual report. The information must relate directly to what extent the CCG has contributed to the delivery of the joint health and wellbeing strategy.
- 1.3 By involving and consulting with the board prior to submission of the annual report to NHS England, the CCG will have ensured it is following the prescribed guidance in preparing its annual report.

2 Background information

- 2.1 NHS England requires all NHS Clinical Commissioning Groups (CCGs) to produce annual reports in a prescribed format to a specific timescale.
- 2.2 The annual report has three sections:
 - Performance Report, including an overview and performance analysis
 - Accountability Report, including a corporate governance report, CCG members' report, statement of the Accountable Officer's responsibilities, governance statement and remuneration and staff report
 - Annual Accounts
- 2.3 One of the statutory requirements is for CCGs to review to what extent they have contributed to the local joint health and wellbeing strategy, to include this review in our annual reports and to consult with the Health and Wellbeing Board in preparing them.
- 2.4 The CCGs Partnership has contributed to the development of the *Leeds Health and Wellbeing Board: Reviewing the year 2017-2018* paper, which is being considered by Health and Wellbeing Board on 19 February 2018. This included the information submitted by the CCGs Partnership to the self-assessment workshop held for Board members in January 2018. This submission provided an overview of how the organisation had contributed to each of the 12 priorities within the Leeds Health and Wellbeing Strategy 2016-2021. The contents of this paper and discussions by the Board on 19 February 2018 will be used to summarise the key achievements of the CCG Partnership in relation to the delivery of the strategy as outlined by NHS England in its annual reporting guidance for CCGs.

3 Main issues

- 3.1 We consider effective partnership working to be fundamental to the way we do our business as CCGs and reflect this throughout our annual reports.

- 3.2 Each of the NHS Leeds CCGs is represented on the Leeds Health and Wellbeing Board. We actively supported the Joint Strategic Needs Assessment (JSNA) to identify the current health and wellbeing needs of local communities and highlight health inequalities that can lead to some people dying prematurely in some parts of Leeds compared to other people in the city.
- 3.3 We consider ourselves to be full partners in commissioning health and care services for the benefit of local people, actively supporting the 12 priority areas:
- A child friendly city and the best start in life;
 - An age friendly city where people age well;
 - Strong, engaged and well-connected communities;
 - Housing and the environment enable all people of Leeds to be healthy;
 - A strong economy, with local jobs;
 - Get more people, more physically active, more often;
 - Maximise the benefits from information and technology;
 - A stronger focus on prevention;
 - Support self-care, with more people managing their condition;
 - Promote mental and physical health equally;
 - A valued, well trained and supported workforce; and
 - The best care, in the right place, at the right time.
- 3.4 Last year we presented text that we needed sign off from Leeds Health and Wellbeing Board members. However this year we want to offer a greater opportunity for members to actively contribute to this year's annual report and agree the key achievements that we have collectively delivered on the Leeds Health and Wellbeing Strategy 2016-2021.
- 3.5 Furthermore we wanted to acknowledge feedback last year about developing a summary version of the annual report. We wanted to confirm to Board members that this was done and we will be following the same format this year. This means we will have a formal annual report and accounts that meets statutory guidance and a summary document that provides a more accessible review of our achievements, how we have involved citizens and how we have allocated our budget.
- 3.6 The process we are working to is as follows:
- Using feedback from the 19 Feb 2018 meeting of the Leeds Health and Wellbeing Board, the CCG will liaise with relevant officers to draft the text
 - Mid-March – The CCGs will brief the Chair of the Leeds Health and Wellbeing Board with the proposed draft text prior to seeking comments from other members.
 - Late-March – Circulate the draft text to Leeds Health and Wellbeing Board members with an offer of a briefing and allow one week to receive comments. The final comments need to be received by 28 March 2018.

- 9 April – Circulate final draft text to Leeds Health and Wellbeing Board members for information only.
- 20 April by midday – The CCG draft annual report will be submitted to NHS England, the draft final version will be circulated to Leeds Health and Wellbeing Board members and for it to be retrospectively noted at the next public Leeds Health and Wellbeing Board meeting.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 All CCG annual report must demonstrate how they have met their statutory duty to involve the public in our commissioning activity. The guidance, for reference purposes, is as below.
- 4.1.2 *"Please explain how the CCG has discharged its duty under [Section 14Z2 of the NHS Act 2006 \(as amended 2012\)](#) to involve the public (individuals and communities you serve) in commissioning activities and the impact that engagement activity has had. This includes designing and planning, decision-making and proposals for change that will impact on individuals or groups and how health services are provided to them. It is a statutory requirement to demonstrate how this duty has been met in your annual report."*

4.2 Equality and diversity / cohesion and integration

- 4.2.1 The annual report includes a contribution from our equality lead demonstrating how the CCG has met its duty to the equality, diversity and inclusion agenda. The CCG annual report also demonstrates how it contributes to reducing health inequalities either through the work of the health and wellbeing board or through local schemes, often at neighbourhood level, through its member GP practices.

4.3 Resources and value for money

- 4.3.1 The CCG annual report is a publically published document that provides an open and transparent reflection on our performance over the year. It also offers taxpayers the opportunity to see how we have made use of our publicly-funded resources.

4.4 Legal Implications, access to information and call In

- 4.4.1 There are no access to information and call-in implications arising from this report.

4.5 Risk management

- 4.5.1 A risk register is held and regularly monitored by the NHS Leeds Clinical Commissioning Groups Partnership.

5 Conclusions

- 5.1 Reflecting on feedback from last year's engagement with the Leeds Health and Wellbeing Board for this statutory requirement of our annual report we have

ensured that it is presented in a timely manner. This gives members a chance to contribute to this particular statutory requirement as part of the wider prescribed set of guidelines that govern the preparation and presentation of the CCG annual report.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Support the process for developing the CCG annual report as outlined in para 3.6 to meet the statutory requirement outlined by NHS England.
- Acknowledge the extent to which the NHS Leeds CCGs have contributed to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021.
- Agree to the formal recording of this acknowledgement in the NHS Leeds CCGs' annual reports according to statutory requirement.

7 Background documents

None

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How does this help reduce health inequalities in Leeds?

The annual report of the NHS Leeds CCG Partnership highlight joined up working to reduce health inequalities, outlining plans, targets and achievements.

How does this help create a high quality health and care system?

The annual report provides a narrative on how the NHS Leeds CCG Partnership has worked in partnership to help create and sustain a high-quality health and care system.

How does this help to have a financially sustainable health and care system?

The annual reports outlines how the CCG is working in partnership across the Leeds health and social care economy as part of the wider STP and Leeds Plan process.

Future challenges or opportunities

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Appendix 1: Excerpt from CCGs annual report 2016-2017

PERFORMANCE REPORT – REDUCING HEALTH INEQUALITIES

Reducing health inequalities is a priority for us as we seek to address the life expectancy gap in some of our neighbourhoods. We want to ensure local people get the support they need to help them make healthy lifestyle choices and to work in partnership to address the wider determinants (causes) of ill health. Our work in this area links in with the Leeds Health and Wellbeing Strategy, the West Yorkshire and Harrogate Sustainability and Transformation Plan and the linked Leeds Plan.

Our varied population covers parts of the most affluent and parts of the most deprived areas of Leeds, and includes communities with some of the lowest average life expectancy rates in the city.

Health and lifestyle

- Cancer, cardiovascular disease and respiratory disease are the leading causes of premature and avoidable mortality. Cases of these are almost double for men.
- There is a strong link between years of life lost and deprivation. Rates are around 60% higher in our most deprived areas. However, overall rates and the gap have reduced.
- Some of the key lifestyle information for our area shows that one in five people are obese and one in five people smoke. Admissions to hospital due to alcohol are 4% lower in our area than the city average.
- Rates of hypertension and chronic obstructive pulmonary disease, often referred to as COPD (the name given to a range of respiratory conditions), vary across the city.
- Over 25% (more than one in four) of adults have one or more long-term conditions.
- Around 16% of children and young people under the age of 16 have asthma.

We've been working on a number of initiatives to help us reduce the health inequalities that affect people in our area. We've highlighted these below.

Supporting people with learning disabilities

We've been developing and implementing the Leeds Transforming Care Partnership (TCP) and local plan to deliver the national three year plan "Building the Right Support". The plan is to develop more effective community services for people with learning disabilities and/or autism with complex behaviour. This helps to support discharge from, and prevent admission to, specialised assessment and treatment or continuing rehabilitation and recovery hospitals.

The TCP is a partnership consisting of commissioners and providers working in adult health and social care and children and young people's social care. A three year plan has been published including an easy read version

www.leedsnorthccg.nhs.uk/news/transformation-care-plan-people-learning-disability-andor-autism/

The programme is to be completed by March 2019. One of the key principles is ensuring service users and families are at the centre of the programme of work. To support this co-production is an essential component of the delivery plan. A workshop with service users and families was held to agree the model and approach supporting the delivery of the plan.

In addition seven work streams have been identified and agreed to deliver the strategic objectives of the all-age plan by the TCP.

Work to improve the health and wellbeing of people with learning disabilities has also been a focus of work this year. The Making Time Pharmacy Project is a new initiative to support improved access to local pharmacies for people with learning disabilities. The initiative facilitates protected time with pharmacists to identify health needs and develop a health action plan to promote an individual's health and wellbeing. The project has been recognised nationally winning two awards for innovation.

Gypsy and Traveller health improvement project

The project includes a range of initiatives to improve our understanding of the health needs of this community; to develop culturally appropriate service/services and to improve access to primary care.

Working with Gypsy and Travellers, Leeds GATE (Gypsy and Traveller Advocacy Group) and York Street Practice we developed and recruited an Outreach Nurse. The Outreach Nurse started in January 2017 building relationships between the Gypsy and Traveller community and primary care, providing health advice and revised health checks. Gypsy and Traveller residents from Cottingley Springs and Leeds GATE were members of the recruitment panel for the Outreach Post. They've also co-designed the approach to the project and evaluation. Links have been established across the Leeds clinical commissioning groups to share learning from the project.

Other initiatives to support the project include:

- Providing healthy lifestyle sessions and revised health checks at the Lee Gap Fair – a traditional Gypsy and Traveller Horse Fair held annually in West Ardsley
- Cultural awareness training commissioned for primary care staff with initial sessions delivered in the Morley locality
- Cottingley Springs residents linked to targeted health improvement work such as screening and cancer awareness
- Developing an academic partnership with Leeds Beckett University to support evaluation

Social prescribing

We've recognised the impact of wider determinants of health on the health and wellbeing of our population. As a result we've invested in a partnership collaboration of local third sector organisations to offer social prescribing for vulnerable patients.

Our social prescribing projects enable patients and communities to actively self-manage their health issues through peer support and access to local third sector groups and services. The main aim is to improve the wider health and wellbeing of patients and to enable GPs to have an alternative to the traditional medical based models of care.

We have supported extensive links and service connections for patients to a wide range of local community and voluntary services such as healthy living services, financial inclusion, housing, domestic abuse and drugs and alcohol agencies.

Mental health

We understand the importance of ensuring people have access and support when they are experiencing mental ill-health or distress. In 2016-2017 we've been working on a number of projects to help support people access treatment and advice quickly.

- MindWell, the new citywide mental health information and self management website, was launched on World Mental Health Day in October 2016. It has been developed through an extensive co-production process and is increasingly being used by GPs and other professionals as well as the general public as the "first port of call" for information. In recognition of its work with services users, Mindwell won a patient engagement award.
- With funding from NHS England's West Yorkshire Vanguard project we've established crisis cafés. We've commissioned two third sector agencies to establish the Well Bean Café running on Saturday, Sunday and Monday evening from 6-12.00 in Lincoln Green near St. James's Hospital. It offers a non-clinical alternative to A&E.
- We've been working with Leeds and York Partnership NHS Foundation Trust to deliver the CORE 24 standards. An agreed reconfiguration has been agreed to improve access for all ages, but further investment is required to deliver the 24 hour cover and 1 hour response times.
- We have a well -established cross sector crisis care partnership group that includes West Yorkshire Police, Yorkshire Ambulance Service NHS Trust, staff working in mental health or A&E, and community and voluntary sector organisations. The group has continued to meet to work on continual improvements to the mental health crisis pathway.
- As part of the Leeds Maternity Strategy we have worked jointly to develop the new citywide perinatal mental health pathway – bringing improved connection between existing services and including perinatal information on MindWell.
- The Early Intervention in Psychosis has been expanded in 2016-17 to extend the age range up to 65.
- We've worked with Leeds and York Partnership NHS Foundation Trust to reduce the number of patients being placed 'out of area' for treatment. Changes in care pathways have seen a significant reduction in out of area placements consistently since September 2016 with only 90 bed days (eight people) in total for quarter three. This compares to 424 bed days (25) for quarter two. Quarter four figures won't be available by the time this annual report is published.
- Commissioners have worked collaboratively with clinicians, third sector partners and Adult Social Care (Leeds City Council) to develop a new model for community based services. This was signed off by in October 2016 and is informing service developments and commissioning into 2017/18
- We're piloting new "liaison" roles in primary care to improve the routes to assessment and brief interventions. Currently there are around 10 new practitioners working across the city creating a more multi-disciplinary approach that also includes pharmacist advice and guidance. The primary purpose is to get the patient to the right place first time and avoid unnecessary referrals.
- A public health specialist has been working across the system to refresh the mental health needs assessment due for publication in April 2017.
- Service users in partnership with clinicians have developed a set of "I Statements" for mental health services which clearly state how they wish to be treated by mental health services. These were signed off by the citywide user group in September

2016 and adopted by commissioners who have made them part of all service specifications for 2017/18

Dementia

- We improved dementia diagnosis from 2,348 people on GP registers with a diagnosis (end March 2016) to 2,386 (end Feb 2017). The diagnosis rate (recorded diagnosis as a proportion of estimated prevalence) increased from 78.7% to 79.0%. The methodology for calculating the indicator will change from April 2017, to give a more realistic, and still excellent, figure of c.71.5%. The methodology from 2015-17 created some random variation caused by patient registrations not matching geographic boundaries, which have worked in favour of our reporting figures.
- Despite this, we were judged as “Needs Improvement” for dementia in NHS England’s first publication of the CCG Improvement and Assessment Framework, based on diagnosis rate and the number of people receiving an annual face-to-face review. However, at this first publication, the “performance” regarding annual reviews essentially represents random variation above the 70% criteria at which the GP QOF awards maximum points. Prior to this, CCGs had had no notice to focus on improving annual dementia reviews, so it is doubtful whether it should be used to judge performance until CCGs have had an opportunity to engage with practices and improve.
- GP-hosted memory clinics opened during 2016-17 at Leigh View Medical Centre and West Lodge Surgery, in addition to the established clinic at Woodhouse Medical Centre. This is giving patients and carers an alternative to attending outpatient clinics delivered by Leeds and York Partnership NHS Foundation Trust (LYPFT) at St Mary’s Hospital. LYPFT will evaluate these in 2017-18, but initial feedback from consultants is that the sessions are working well, and patients and carers find the GP-hosted venues much more convenient.
- The memory support worker service completed its first 12 months of operation in October 2016, and established itself very quickly as an easily accessible service for people and families seeking support before and after diagnosis. Citywide, more than 1,500 people were supported in those first 12 months. In spite of a very challenging financial situation, the service has been funded for a further year and evaluation is in progress, including economic evaluation. It has been shortlisted for a Health Service Journal award for ‘Clinical Value’, from a large number of high quality entrants; the winners will be announced in May 2017.
- The CCG continues to work with partners to improve day-to-day support for people and carers living with dementia. We have supported Carers Leeds to continue with hospital-based dementia carer support, and Touchstone Leeds to continue providing support to people from black and minority ethnic (BAME) communities; although again funding remains short-term and sustaining services remains a challenge. We recognise and applaud the excellent work of local community organisations who are addressing the needs of people with dementia, often using independent fundraising and voluntary effort.

Maternity and Children’s Services

We continue to implement the Leeds maternity strategy. Working groups have established a new pathway to improve the identification and support of emotional and mental health needs of pregnant women and women who have just had a baby. The groups are now meeting to ensure pathways are communicated and embedded.

Targeted work has taken place to understand the specific experiences and needs of women with learning difficulties and disabilities in relation to maternity services. As a result of this, various changes have been made, including the introduction of new protocols and accessible information.

Work has continued to move towards more personalised maternity care in Leeds; as part of this, community midwifery teams have been reorganised to better align with children's centres, and a Leeds definition of personalised care has been co-produced with women, families, and clinical staff.

Furthermore, the CCGs have jointly funded, alongside the Department of Health and Leeds City Council, the embedding of the award winning Best Beginnings "Baby Buddy", and the incorporation of specific "Understanding your Baby" with perinatal mental health content. This interactive digital app provides useful support and key health promotion information, as well as local service details throughout the woman's pregnancy.

In December 2016 Ofsted and CQC inspected Leeds partners on their delivery of responsibilities for children and young people with Special Educational Needs and Disabilities (SEND) as referred to in the Children and Families Act (2014). The Inspectors noted a number of key strengths in Leeds including how children and young people who have SEND are proud to be citizens of Leeds and have a voice in improving services in the city. Also the strength of the partnership was noted. Areas requiring some development were also identified. These included the need to ensure Education, Health and Care Plans (EHCP) were child centred and outcome focussed and an improvement of the educational outcomes achieved by this cohort of young people.

In addition we continue to develop and deliver the Local Transformation Plan for children and young people's mental health and wellbeing. This year the Future in Mind: Leeds strategy was launched. There have been some significant achievements including the embedding of the Single Point of Access, the reduction in CAMHS waiting times, and the establishment of a distinct Community Eating Disorder Service for children and young people. There has been the launch of the MindMate champions programme for schools and the development of MindMate Lessons (PHSE curriculum for emotional and mental health).

'Best Start' to life

The Leeds Best Start programme aims to ensure a good start for every baby, with early identification and targeted support for vulnerable families. During 2016-17, we have worked with Leeds City Council and other partners to develop and support the delivery of a local Best Start plan in Bramley. This work has focused on raising awareness of existing services, identifying gaps in services and providing targeted support for vulnerable families. Examples include taking a local smoking cessation service out to people's homes and working with parents to support healthy cooking. Best Start Hyde Park is due to launch in March 2017.

Childhood obesity

During 2016-17, the CCG has worked collaboratively with schools and Leeds City Council to deliver an evidence-based childhood obesity prevention programme. This programme aims to increase fruit and vegetable intake and reduce intake of foods and drinks high in

sugar and fat. The programme has been implemented in five cluster areas (20 primary schools in total) in response to two areas of concern identified through the National Child Measurement Programme. It first looked at areas with levels of childhood obesity that are significantly higher than the national average; secondly, it concentrated on areas where the prevalence of childhood obesity, whilst not above the national average, appears to be increasing.

New Models of Care – community wellbeing

General practices are working with community, acute and third sector providers. They are developing and delivering new models of care which respond to the needs of priority populations within a given locality. Joint leadership teams are being developed and supported to enable provider joint working. We believe this will lead to improved outcomes and increased satisfaction for patients and in improvements to the working lives of front line staff through better working relationships.

For example a 'Community Wellbeing Leadership Team' has been established in the Armley locality. Membership is local leaders drawn from general practice, (representing five GP practices in the area) Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, adult social care (Leeds City Council), the Armley One Stop Centre and the local voluntary sector.

The key aims are to improve relationships, develop local leadership and promote integration. The groups aims to improve the aspirations of people in Armley. The group have identified priorities around mental health, self-care and delivery of care. The group also want to roll out coaching training to all front line clinical and non clinical staff so that all people in the area will receive a consistent response when accessing all services.

Helping to deliver the Leeds Health and Wellbeing Strategy

We've been working on a number of projects that closely link with some of the key objectives set out in the Leeds Health and Wellbeing Strategy. These look to address some of issues that affect people's quality of life and impact on their overall health and wellbeing.

Key citywide statistics from the Leeds Health and Wellbeing Strategy

- Over the next 25 years the number of people who live in Leeds is predicted to grow by over 15 per cent. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030
- 164,000 people in Leeds live in areas ranked amongst the most deprived 10 per cent nationally. One in five children in Leeds live in poverty
- 34% of children aged 11 in Leeds have an unhealthy weight
- It is estimated around 37,000 older people experience social isolation or loneliness
- Physical inactivity is our fourth largest cause of disease and disability. Figures show that around one in five adults in Leeds is inactive
- Cancer deaths account for over 30% of the life expectancy gap between Leeds and the rest of England
- People with severe mental illness die on average 15-20 years earlier than the rest of the population
- 105,000 people in the city suffer from anxiety and depression

Avoidable years of life lost – cancer

We've worked alongside Leeds City Council and Cancer Research UK to improve the **early diagnosis** of lung cancer. This includes working with pharmacies in areas of west Leeds with high smoking prevalence to increase awareness of symptoms of lung cancer, and encourage self-referral for chest x-ray in appropriate patients. GPs were incentivised to improve bowel cancer screening uptake as part of quality premium improvement scheme.

Leeds is one of six pilot sites nationally involved in the **ACE (accelerate, co-ordinate, evaluate) project**. This is funded nationally by Cancer Research UK. The aim of the pilot is to develop and implement a referral pathway for patients with non specific but concerning symptoms where there is a suspicion of cancer. In developing this new pathway it is anticipated that patients that don't usually meet the criteria on to a two week wait referral pathway, will be able to be referred earlier for diagnostic tests.

The patient's GP will be able to refer the patient for a range of blood tests and then make an onward referral into Leeds Teaching Hospitals NHS Trust using an ACE referral form. Patients are then booked for a nurse-led assessment, following which results are discussed at a multi-disciplinary centre and an onward referral decision is made. This could be further investigations/tests, onward referral within the hospital, or discharge back to GP. This new pathway is being piloted nationally and actual referral activity and intelligence will inform the future model development and resource requirements. The following outcomes are expected:

- Better informed and supported GPs in decision making and earlier referral
- Improved integration of primary and secondary care systems for patients with non specific but concerning symptoms
- Improved patient safety
- Focus on continuity and quality of care for patients
- Improved cost effectiveness use of diagnostic resources

Leeds is one of five pilot sites involved in the **28 days to faster diagnosis project**, funded by NHS England. This is a key National Cancer Taskforce recommendation that all patients should receive a 'definitive' diagnosis of cancer or have cancer 'definitely' ruled out within 28 days of an initial referral (and 50% within 14 days). This project will achieve the following outcomes:

- Improved patient safety with improved access to earlier appropriate diagnostics
- Improved patient experience with faster communication of diagnosis for patients
- Improved links and integrated working between primary and secondary care

We're pleased to see Leeds being above the national average for diagnosing cancer at stage 1 or 2. Our performance of 56% against the national average of 50% is for the following cancer sites:

- invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus; and
- non Hodgkin lymphoma and invasive melanoma of skin.

Avoidable years of life lost – cardiovascular disease (CVD)

The Atrial Fibrillation (AF) programme has been focusing on identifying the numbers of people across the CCG area with AF in order to reduce the number of people affected by stroke. Programme findings suggest:

- At the start of the programme, there was a 37% treatment gap in identifying patients with AF. This is now 23%.
- Training provided to manage AF has increased knowledge, skills and confidence among GPs
- Shared decision making tools are available to support the conversation with patients around decision making
- There's been a 50% reduction on patients who previously have been taking aspirin
- Novel oral anticoagulants (NOACs) are a new class of anticoagulant drug. There has been a substantial increase for patients on NOACS with approximately 600 patients now receiving NOACS

Supporting people into employment

In 2016-17 we match-funded the development of a community-led local development (CLLD) strategy for west Leeds. This looks at how people furthest away from the labour market in the most deprived communities can be supported into employment. The strategy was submitted to the European Social Fund and the European Regional Development Fund and was successful in going forward to full application. The result will be €1.5million funding into the area to fund such schemes. We're members of the local action group who will make decisions on how the funding is used.

Unnecessary time spent in hospital

All partners in Leeds are committed to ensuring that patients only spend as much time as they need in hospital. In October 2016, health and social care partners in Leeds established an integrated discharge service within Leeds Teaching Hospitals NHS Trust. The service brings together expertise from across health, social care and the third sector (Age UK) to identify patients that need support from health and social care commissioned services in the community to facilitate their discharge. The service operates seven days a week from 8 till 8 to coordinate the assessment on patients' needs and arrange ongoing care. Our analysis to date is that the services is helping patients to avoid unnecessary stays and, when they're admitted, reducing the time that they need to stay.

Preventable hospital admissions – childhood asthma

Over the last two years, the CCG has funded the delivery of a community-based children's asthma service, which aimed to raise awareness, improve care and reduce hospital admissions. Key components of the project included providing asthma education in schools and early years' settings, developing a risk-stratification tool to identify children most at risk of exacerbation, and developing and implementing protocols and a clinical recording template in primary care to standardise care and reduce variation in care. Local children co-produced a number of resources aimed at raising awareness of the importance of carrying their inhalers at all times.

Preventable hospital admissions – clinical care co-ordinators

In 2016-17 we've continued to fund GP practice based clinical care co-ordinators. The care co-ordinators are hosted by GP practices but link out into the community, working closely with neighbourhood teams and primary and community healthcare services.

The clinical care co-ordinator role:

- is responsible for the initial assessment of patients and the formulation and review of a personalised care plan;

- collects data relating to specific patient outcomes - these will be dependent on the patients requirements;
- is a key contact along with the named accountable GP for the patient;
- is a key person for building and managing the relationship between practices and neighbourhood teams;
- attend case management meetings;
- identify when patients have been admitted/attended A&E and review care plan accordingly; and
- support discharge planning for patients who are admitted to hospital.

PERFORMANCE REPORT – WORKING WITH OUR PARTNERS

Clinical commissioning groups

Discussions have been taking place about how the three CCGs can work together more collaboratively. To support this a project called One Voice has been established. As part of this a joint leadership structure is being set up with one Chief Executive Officer overseeing the work of the three CCGs. Another important role that has been established is that of a Chief Officer for System Integration.

Work is underway to establish citywide committees to cover governance, quality, finance and patient assurance which will be established to replace the current separate structures. The three CCG boards and governing bodies will still have statutory accountability and be governed by each CCG's respective constitutions. These constitutions are in the process of being updated so that the transitional arrangements can be implemented.

On an operational level the Leeds CCGs have been looking at key citywide healthcare services. Our plans are set in the context of national guidance as well as the West Yorkshire and Harrogate Sustainability Transformation Plan (STP) and the Leeds Plan.

The Leeds CCGs have taken on joint responsibility with NHS England to co-commission primary care (GP) services. This means we're working with our respective member GP practices to look at how we can improve access and quality in primary care GP services.

To support this the Leeds CCGs have put together a five year plan in direct response to the NHS GP Five Year Forward View. We have six ambitions that will help us to deliver the GP Five Year Forward View. These are:

- supporting and growing the workforce;
- improving access;
- transforming estates and technology use;
- better workload management; redesigning care delivery and resourcing primary care.

You can find out more by reading our plan:

www.leedswestccg.nhs.uk/content/uploads/2016/06/Leeds-GPFV-Plan-Final-Version.pdf

Ensuring that children enjoy the best possible start to life is a citywide priority as outlined in the Joint Health and Wellbeing Strategy. As part of our efforts to support this the Leeds CCGs are reviewing maternity services. This is an ongoing long-term review that has to date involved a number of key partners as patients and their families. This links in with the

Leeds Maternity Strategy 2015-2020:

www.leedswestccg.nhs.uk/about/publications/maternity-strategy-for-leeds-2015-2020/

Our city's Joint Health and Wellbeing Strategy prioritises the mental health of citizens in Leeds. We've been continuing to invest in services that improve the mental health and wellbeing of people.

For children and young people we've continued to invest in child and adolescent mental health services (CAMHS) in direct response to feedback from service users and their families. We acknowledge that waiting times for services are high however our investment is beginning to make a difference. We've also continued to work with children and young people to further develop Mindmate. Mindmate is a website offering advice and support as well as signposting information for children and young people, parents/carers and frontline professionals.

Issues affecting access to mental health services are not restricted to children and young people. Therefore we've increased our efforts to ensure adults can get the support they need at times of mental ill-health. We've increased investment leading to improved capacity to deliver IAPT (improving access to psychological services).

Similarly to our work with children and young people, we've involved citizens to help us develop a new single point of access website for adult mental health, MindWell. MindWell is the single 'go to' place for information about mental health in Leeds. It provides a portal for anyone living or working in Leeds, including GPs and other professionals, to get quick and easy access to up-to-date mental health information.

Antimicrobial resistance is one of the biggest threats to the health and wellbeing of people with scientists warning that if more isn't done then there's a risk that antibiotics will no longer work. We've been working with our partners to improve understanding of antimicrobial resistance among healthcare professionals and the wider public. This includes working with prescribers reducing the prescribing of antibiotics where they're not needed and developing awareness campaigns so that the public are aware of the risks of the overuse of antibiotics. We're also promoting linked messages to reduce the spread of infections such as effective hand washing and spotting the signs of sepsis.

West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)

The West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) published during the year, aims to address the health and wellbeing gap with a focus on supporting people to live longer, healthier lives and ensuring a good and equitable service for all, no matter where people live. It also stresses the importance of improving people's health, through better co-ordination of services, while improving the quality of care received.

It has identified nine priorities for the West Yorkshire and Harrogate area:

- Prevention
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised services

- Hospitals working together
- Standardisation of commissioning policies

More information about the STP: www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/

The Leeds Plan

Complementing the STP, but also taking forward the vision to make the city *'a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'* is the Leeds Plan.

The Plan itself is still under development, led by Leeds City Council and supported by NHS organisations and the third sector.

Its key themes are:

- Prevention
- Self-management, proactive and planned care
- Optimising the use of secondary care resources and facilities
- Urgent and emergency care and rapid response

Leeds Health and Wellbeing Board

We have a seat on the Leeds Health and Wellbeing Board which has been established as a statutory committee of Leeds City Council. We actively supported the Joint Strategic Needs Assessment (JSNA) using a range of information and local and national statistics to identify the current health and wellbeing needs of our communities and highlighting health inequalities that can lead to some people dying prematurely in some parts of Leeds compared to other people in the city. The findings from the JSNA fed into the Joint Health and Wellbeing Strategy for Leeds 2016-2021:

www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf

We consult regularly on a formal and informal basis with the HWB, its membership and its Chair. In particular, we consult with the HWB on our strategies and plans, and how these contribute to the delivery of the health and wellbeing strategy for Leeds. For example, in preparation for the submission of plans for 2017-2018 we have provided a full analysis of how our plans and priorities meet the HWB's vision for health and care in the city. Prior to submitting our annual report to NHS England we consulted with our Health and Wellbeing Board as part of our formal requirements to do so.

The Joint Health and Wellbeing Strategy has 12 priority areas:

- A child friendly city and the best start in life;
- An age friendly city where people age well;
- Strong, engaged and well-connected communities;
- Housing and the environment enable all people of Leeds to be healthy;
- A strong economy, with local jobs;
- Get more people, more physically active, more often;
- Maximise the benefits from information and technology;
- A stronger focus on prevention;
- Support self-care, with more people managing their condition;
- Promote mental and physical health equally;

- A valued, well trained and supported workforce; and
- The best care, in the right place, at the right time.

Listed below are some examples of the progress we have made this year.

- We've kept members of the Health and Wellbeing Board informed of our work around the West Yorkshire and Harrogate Sustainability Transformation Plan and the linked Leeds Plan. This included highlighting current and anticipated pressures on the health and care system, efforts to address these and wider system resilience.
- Agreement on the Better Care Fund for 2016-2017. Plans included how partners will work to meet national conditions for social care, a joint approach to assessment and care planning including integrated care and a local plan to reduce delayed transfers of care.
- Tackling health inequalities and wider issues (determinants) that can lead to ill health. This included looking at issues such as poverty, air quality and taking action to reduce incidences of domestic abuse. However the Health and Wellbeing Board noted the continued funding cuts for public health and the impact this has on prevention initiatives leading to concerns to the impact this will have on health inequalities.
- There are over 250,000 people in Leeds under the age of 25. 10% of these young people are likely to have a mental health issue or need support with their emotional wellbeing. The Health and Wellbeing Board approved the Future in Mind Report to transform how support is offered and improvements can be made to the emotional and mental health of children and young people in Leeds. This included outlining plans on improving the support provided to children with Special Educational Needs and Disabilities (SEND). A copy of the strategy can be downloaded: www.leedswestccg.nhs.uk/about/publications/future-mind-leeds-local-transformational-plan-2016-2020/
- Carers play a valuable role in helping health and social care services often at great personal cost – both financially and emotionally. As a result the Health and Wellbeing Board signed up to the Leeds Commitment to Carers. The commitment has been supported by insight from carers gathered by Carers Leeds.

The Health and Wellbeing Board discussed a paper at its meeting on 20 April 2017, which brought together extracts of the draft annual reports from the three Leeds CCGs. These gave examples of partnership working in contributing to the delivery of the city's health and wellbeing strategy.

The Health and Wellbeing Board acknowledged the extent to which the CCGs had contributed to the health and wellbeing strategy. The board asked that in future the CCGs engage with members on our annual reports at an earlier stage. The agenda for the meeting on 20 April (with reference to item 9) can be found by visiting: <http://democracy.leeds.gov.uk/ieListDocuments.aspx?CId=965&MId=7729&Ver=4>

Scrutiny Board (Adult Social Services, Public Health, NHS)

The Scrutiny Board (Adult Social Services, Public Health, NHS) reviews and scrutinises the performance of Adult Social Services, Public Health and the local NHS. The Scrutiny Board also reviews and scrutinises decisions taken by the Executive Board relating to

Adult Social Care. Throughout 2016-2017 we have continued to keep the Scrutiny Board informed of our key decisions and plans to assure we meet our duties to consult as outlined in the NHS Act (2006).

As co-commissioners we received our first proposal from a GP practice looking to close a branch surgery. Abbey Grange Medical Practice submitted an application to close their branch practice at Holt Park. We advised the practice on how they would need to engage with their registered patients. In addition we informed the Scrutiny Board and kept them updated on the latest position. This included confirmation that the CCG's primary care commissioning committee had accepted the application to close the branch surgery.

In 2016-2017 we also updated the Scrutiny Board on the following areas.

- Work on developing the West Yorkshire and Harrogate Sustainability Transformation Plan and associated Leeds Plan.
- Primary care including co-commissioning of services with NHS England
- Concern was raised around cancer waiting times in some specialities. however the Board was informed of the progress made in this area and how Leeds has some of the quickest access to diagnostic services.
- Updates were provided throughout the year on how the NHS is responding to local pressures including A&E targets, waiting times for routine procedures and delayed transfers of care.
- Leeds' response to the NHS GP Five Year Forward View.
- One voice collaborative approach being adopted by the Leeds CCGs.

Our NHS providers

We are pleased to be able to commission services from three NHS trusts in Leeds alongside other service providers. We lead on commissioning services from Leeds Teaching Hospitals NHS Trust with NHS Leeds North CCG leading on commissioning services from NHS Leeds and York Partnership NHS Foundation Trust and NHS Leeds South and East CCG taking the lead on Leeds Community Healthcare NHS Trust. Our ambulance services are provided by Yorkshire Ambulance NHS Trust who also are the provider of NHS 111 for our region. In addition to this we fund services from a number of neighbouring providers so that we can uphold the rights of our patients to choose where they go for treatment where it is appropriate to do so.

Some of the highlights from the year include:

- Working with Leeds Teaching Hospitals NHS Trust, as well as community partners and academics, to look at how cancer pathways can be improved. This covers all parts of the pathway from diagnosis, treatment and ongoing care. The work we've done has helped set up the Leeds Cancer Strategy 2016-2021.
- Working with a range of partners including Leeds Community Healthcare NHS Trust and Leeds and York Partnership NHS Foundation Trust to set up a community wellbeing leadership team in Armley. This will help establish integrated care that is delivered within the community as well as encouraging people to self-care.

You can find out how well our NHS providers are doing in the performance section of the annual report. Further details can also be found on our website as we publish an integrated quality and performance report for each Governing Body meeting:

www.leedswestccg.nhs.uk/about/governing-body/meetings/

Leeds City Council

Leeds City Council commissions care and support services and is responsible for public health, which is a body of work that seeks to protect and improve health and wellbeing.

The future direction of health and care services set out in the NHS Five Year Forward View is around closer integration of health and social care services. These services would be delivered at a locality or neighbourhood level by care teams working together rather than working to their own organisation's boundaries. We've already started making progress in setting up one of the 'New Models of Care' and in 2017-2018 we've made significant progress in establishing our first pilot site in Armley. As a result we now have a community leadership team that will help us deliver our plans to bring co-ordinated care closer to home, reducing the need for hospital-based care. To do this we've been working with a range of partners including Leeds City Council.

We welcomed the publication of the Director of Public Health's Annual Report and acknowledged the key areas that need to be addressed to improve the health of the population. This includes encouraging people to adopt healthier lifestyles and to take part in initiatives to protect their health, such as the NHS Health Check, the flu jab or cancer screening.

We worked with Leeds City Council and community organisations to launch a strategy to reduce the number of suicides in the city. The Leeds Suicide Prevention Strategy is based on an audit of detailed findings of suicides to identify interventions that could help prevent people from taking their own lives. The Leeds Suicide Audit is considered to be the 'gold standard' of best practice and is recommended by Public Health England as a model for other areas to learn from.

We have also been working closely with Leeds City Council to deliver key public health campaigns. In the last year we have been promoting a campaign encouraging patients to dispose of medicine waste, such as syringes, safely to reduce the risk of injury to environmental waste officers and members of the public. We've also worked with the council to run a winter wellbeing campaign encouraging people to make the best use of NHS resources as well as accessing support from services such as meals on wheels.

Community and voluntary sector organisations

The role of the community and voluntary sector (often referred to as the third sector) is crucial not only for the delivery of services but also to provide us with an opportunity to engage with some community groups who are sometimes referred to as 'seldom heard groups.'

Over the past 12 months we have been working with local community groups to run a number of engagement events and activities so that we can continue to develop services that meet local needs.

Our patient empowerment project (PEP) provides social prescribing options for GPs so that they can refer people to PEP, who in turn puts patients in touch with community groups and services that can help them. Social prescribing looks at wider issues that can affect a person's health that are not medical reasons such as debt or bereavement. A social prescription then links a patient in with services that can help tackle the root cause

of their ill health. Our PEP project is delivered by a consortia of community and voluntary sector organisations including BARCA-Leeds, Leeds Mind and Better Leeds Communities.

A decision was undertaken to cease funding for non-medical circumcision services. To help inform members of the public we worked with families who had used the service, local religious leaders, local GP practices and other services who work with families.

We've worked with our community and voluntary sector partners to develop a new approach to the NHS Equality Delivery System in the engagement and assessment of grades. This is a uniform approach adopted by all Leeds NHS organisations and has been developed by taking in the views of key partners including Healthwatch Leeds, Voluntary Action Leeds, Leeds Involving People and Forum Central.

The new Mindwell mental health website for Leeds was developed in conjunction with a range of community groups co-ordinated by Volition, allowing us to work with people to co-produce the site. Volition is a network of third sector, not-for-profit organisations that support people's mental health and wellbeing in Leeds.

We were delighted that our partners Carers Leeds won a prestigious Health Service Journal Award for the work they do to advocate on behalf of the city's carers. Carers Leeds won an Integrated Commissioning for Carers award in recognition of its integrated approach to carers support. Carers Leeds have also helped the city to develop a Leeds Commitment to Carers.

Healthwatch Leeds

Healthwatch Leeds is represented on the Leeds Health and Wellbeing Board, giving patients and communities a voice in decisions that affect them. We have worked with Healthwatch Leeds to gather patient insight on local health services including an extensive survey and interview to capture the experiences of patients as part of our extended access to primary GP services scheme.

Healthwatch Leeds have also undertaken a number of reviews of services and published subsequent reports with recommendations. We'll be looking at how we can use the recommendations from these reports to influence how services are provided in the future. The reports are for the following:

- review of sexual health clinics in Leeds;
- service users' experience of aspire, providing care and support services for adults with learning disabilities; and
- home care services for people receiving support in their own home.

Care Quality Commission

The Care Quality Commission (CQC) is the registration body responsible for monitoring standards of care, and undertakes announced and unannounced inspections to providers either as a matter of routine or in response to concerns raised by patients and staff. To support sharing of information and intelligence on quality and standards of care the Leeds Quality Surveillance Group, represented by all three CCGs, also includes a representative from the CQC.

In 2016-2017 the CQC inspected all our 37 member GP practices and reports for 36 of them had been received at the time of writing. We were pleased that five of our practices

received an outstanding rating and 30 were rated as good. Unfortunately one of our practices was rated as requires improvement.

The CQC also undertook inspections of three NHS provider trusts in the city. At the time of writing we received reports for two of the three. We're pleased that Leeds Teaching Hospitals NHS Trust has moved to a good rating from its previous position of requires improvement. However Leeds and York Partnership NHS Foundation Trust was rated as requires improvement.

Leeds Academic Health Partnership

The Leeds Academic Health Partnership is made up of the city's three universities, NHS organisations and Leeds City Council. The partnership has been set up to use innovations, education and research to improve health and care outcomes.. One of the areas the partnership has worked on is personalised medicines. This is looking at how health and care professionals can work with patients to provide tailored treatment that is most likely to have the desired health benefits.

Leeds Informatics Board

The Leeds Informatics Board (LIB) is responsible for the governance framework for informatics developments in Leeds. LIB is supported by a number of sub-committees, including a cross-city Information Governance Steering Group and City Informatics Clinical Group.

Using technology is central to transforming services and is helping to deliver the ambitions of the city. During the year a wide range of achievements have been developed under the leadership of LIB outlined below.

- Leeds Local Digital Roadmap was produced in conjunction with the West Yorkshire and Harrogate Sustainability Transformational Plan and in collaboration with other Local Digital Roadmaps across West Yorkshire. It provides a consolidated view of the plans describing a five-year digital vision, a three-year journey towards becoming 'paper free at the point of care' and two-year plans for progressing a number of predefined 'universal capabilities'.
- Another major achievement has been the inclusion of adult social care and community information to the Leeds Care Record. Leeds Care Record now covers five major care settings viewing and contributing information across the city including GPs, hospital, mental health, adult social care and community. We have also significantly increased to 4,000 active users, a huge leap from April 2016 when there were 2,500 users.
- Leeds Intelligence Hub continues to drive change in commissioning by providing system wide data analysis and insight.
- Excellent progress has been made on some national targets including electronic prescribing between GPs and pharmacists. GPs in Leeds are quick adopters of the national electronic prescription service (EPS) making prescribing and dispensing medicines more efficient and convenient for patients and NHS staff. 100 GP practices in Leeds (over 95% of 104) can digitally send prescriptions directly to the patient's preferred pharmacy through their own IT system, removing the need to write paper prescriptions. Patients are now able to collect their repeat prescriptions from the pharmacy without the need to visit the GP practice. It also means that patients don't have to worry about losing their paper prescription, making the process safer and more secure.

- Patients and healthcare professionals visiting nearly all of the GP surgeries in Leeds can now connect to the internet using free WiFi.
- Six care homes in Leeds are involved in a pilot scheme which allows health and care staff to remotely monitor the health of residents and reduce the need to admit residents to hospital as an emergency'.
- Leeds is now transferring patients' electronic health records directly, securely and quickly between their old and new practices when they change GPs. The system called GP2GP helps improve patient care by making full and detailed medical records available to practices, for a new patient's first and later consultations.
- Leeds Health Pathways has standardised clinical pathways, medication and guidance to all care professionals in the city. It is managed and supported by Leeds Teaching Hospital NHS Trust and replaces the Map of Medicine which was used by primary care. It's a great example of how collaborative working across organisations can create impressive results that help to ensure that consistent care and pathways are available across the city.

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Leeds Health and Wellbeing Board



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Report of: Steve Hume (Chief Officer Resources & Strategy, Adults & Health, Leeds City Council) & Sue Robins (Director of Operations & Delivery, Leeds CCGs Partnership)

Report to: Leeds Health and Wellbeing Board

Date: 19th February 2018

Subject: iBCF (Spring Budget) Q3 2017/18 Return and BCF Performance Monitoring Q3 2017/18 Return

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The Leeds iBCF Spring Budget return for Quarter 3 of 2017/18 (Appendix 1) and the Leeds HWB BCF Performance Monitoring return (Appendix 2) for the same period were submitted to the Department for Communities and Local Government (DCLG) and NHS England (NHSE) respectively by the deadline of 19th January 2018. The quarterly returns were reviewed and approved by the Leeds Health and Wellbeing Board members via email and this paper is provided to the Health & Wellbeing Board (HWB) for information.

The DCLG requires Local Authorities to submit quarterly returns regarding their use of the 'Spring Budget' adult social care element of local Better Care Funds (BCF).

NHSE requires HWB areas to complete and submit the BCF performance monitoring quarterly return to ensure the requirements of the BCF are met and enable areas to provide insight on health and social integration.

The iBCF Spring Budget returns are distinct from the BCF performance monitoring quarterly returns however, the deadlines for both these returns have now been synchronised.

The completion and submission of the iBCF Spring Budget quarterly return allows central government to monitor the success of the BCF/iBCF/Spring Monies and to provide insight on health and social integration.

This report and the relevant returns indicate that Leeds are complying fully with the national conditions of the BCF and that in relation to performance against the key national performance indicators Leeds is on target to meet those for Non-Elective Admissions and the Rate of Admission to Residential Care, however, Leeds performance on the effectiveness of reablement and Delayed Transfers of Care currently remain below target. The reablement service has recently undergone a significant expansion and there is an expectation that the temporary drop in performance will be rectified for the next quarter. The performance on Delayed Transfers of Care is improving, particularly those delays at LTHT where delays attributable to Social Care are currently below target, and those attributable to the NHS are significantly improved. However, in relation to LYPFT delays progress has been more mixed, largely as a result of the previous under-reporting outlined at the last HWB meeting.

The iBCF return details the progress made against the range of 'Invest to Save Schemes' which have all now been through a robust review of individual business cases. Most schemes are now in the mobilisation stages.

Recommendations

The Leeds Health and Wellbeing Board is asked to:

- Note the contents of this report,
- Note the contents of the Leeds iBCF Quarter 3 2017/18 return to the DCLG, and;
- Note the content of the Leeds HWB BCF Performance Monitoring return to NHSE for quarter 3 of 2017/18.

1 Purpose of this report

- 1.1 To inform the HWB of the contents of the national iBCF return and the Leeds HWB BCF Performance Monitoring return for 2017/18 Quarter 3.

2 Background information

- 2.1 The national grant conditions for iBCF Spring Budget funding are:
- Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
 - A recipient local authority must:
 - a) Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption;
 - b) Work with the relevant clinical commissioning group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19;
 - c) Provide quarterly reports as required by the Secretary of State.
- 2.2 In Leeds, we have used this non-recurrent three year funding to fund transformational initiatives that have compelling business cases to support the future management of service demand and system flow and prevent and delay the need for more specialist and expensive forms of care.

This is founded on the principles of the Leeds Health and Care Plan, which sits under the Leeds Health & Wellbeing Strategy) and links to the West Yorkshire & Harrogate Health and Care Plan.

Each bid is supported by a robust business case which will address the challenges faced around health and wellbeing, care quality and finance and efficiency. A robust approach has been established which will:

- Measure the actual impact of each individual initiative
- Monitor actual spend on each initiative and release funding accordingly
- Ensure that appropriate steps are being taken to identify ongoing recurrent funding streams after the iBCF funding period ends in cases where initiatives prove to be successful
- Ensure that exit strategies are in place for initiatives that do not achieve their intended results

3 Main issues

iBCF (Spring Budget) 2017/18 Quarter 3 Return

- 3.1 The return details twenty of the thirty-six iBCF initiatives that are being funded. Only twenty schemes are covered in detail on the return because, according to the DCLG, the spread-sheet is not designed for such a large number of projects. On

the advice of DCLG it was decided to only include detail on the top twenty schemes with the highest overall investment. These are:

Falls Prevention
Neighbourhood Networks
Leeds Community Equipment Services
Local Area Coordination (LAC)
Transitional Beds
Better Conversations
Lunch Clubs
The Conservation Volunteers (TCV HOLLYBUSH) - Green Gym
Positive Behaviour Service
Falls Pathway Enhancement (LCH)
Skills Reablement Service
Health Partnerships team
Yorkshire Ambulance Service Practitioners scheme
Frailty Assessment Unit
Hospital to Home
Staffing resilience
Respiratory Virtual Ward
Trusted Assessor (LGI)
Trusted Assessor (SJH)
Alcohol and drug social care provision after 2018/19

3.2 The remaining sixteen schemes are included in a full list provided in the narrative. These are:

Dementia: Information & skills (online information & training)
Time for Carers
Working Carers
Asset Based Community Development (ABCD)
Prevent Malnutrition Programme
Peer Support Networks
Ideas that Change Lives (ITCL) investment fund
A&H - Change Capacity
Telecare Smartoom
Assisted Living Leeds Volunteer Drivers
Learning & Information Resource in recovery hubs

Business Development Manager for Assistive Technology post
Business Support for Discharge Process
Rapid Response
Supporting Wellbeing and Independence for Frailty (SWIFt)
Customer Access

- 3.3 The majority of the individual schemes are at the early stages of development as can be seen in the progress comments for the twenty schemes. This is due to the review of schemes by a cross-partner Panel held on 7th December 2017 prior to release of funds.

The purpose of the Panel was to ensure there was confidence that each bid was supported by a robust business case which addressed the challenges we face (health and wellbeing, care quality and finance and efficiency). The cross-partner nature of the panel was intended to bring a different system perspective and constructive challenge to ensure that collectively there was a balanced and holistic evaluation.

The Panel was considered very successful and all members agreed it was a useful process which would promote better conversations in the future, ensuring that as a partnership we are in the best position to deliver the right outcomes for the citizens of Leeds.

- 3.4 In response to the questions in the return we calculate that the additional Spring Budget funding has the potential to fund 11,000 additional home care packages (126,000 hours) and an extra 219 care home placements. However, it should be noted that Leeds has the continued aim of reducing care home bed weeks by better meeting people's needs within their own homes and communities.
- 3.5 This strategic direction is reflected by the two locally devised metrics for measuring the impact of the Spring Budget monies that we have proposed in the return:
- Number of commissioned care home weeks (65+);
 - Percentage of new client referrals for specialist social care which were resolved at point of contact or through accessing universal services.
- 3.6 Additional metrics, yet to be agreed, based on the schemes are being considered for inclusion in the Quarter 4 return.

BCF Performance Monitoring Return Quarter 3 Return for 2017/18

- 3.7 The Quarter 3 BCF Performance Monitoring Return indicate that Leeds are complying fully with the national conditions of the BCF and that in relation to performance against the key national performance indicators Leeds is on target to meet those for Non-Elective Admissions and the Rate of Admission to Residential Care, however Leeds performance on the effectiveness of reablement and Delayed Transfers of Care currently remain below target. The reablement service has recently undergone a significant expansion and there is an expectation that the temporary drop in performance will be rectified for the next quarter. The

performance on Delayed Transfers of Care is improving, particularly those delays at LTH where delays attributable to Social Care are currently below target, and those attributable to the NHS are significantly improved. However in relation to LYPFT delays progress has been more mixed, largely as a result of the previous under-reporting outlined at the last HWB meeting.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 Routine monitoring of the delivery of the BCF is undertaken by a BCF Delivery Group with representation from commissioners across the city. This group reports in to the BCF Partnership Board, which in turn reports to the Leeds Health and Wellbeing Board in relation to the BCF. The BCF Plans in Leeds have been developed based on the findings of consultation and engagement exercises undertaken by partner organisations when developing their own organisational plans.

Any specific changes undertaken by any of the schemes will be subject to agreed statutory organisational consultation and engagement processes.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. The vision that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest' underpins the Leeds Health and Wellbeing Strategy 2016- 2021. The services funded by the BCF contribute to the delivery of this vision.

4.3 Resources and value for money

- 4.3.1 The Spring Budget iBCF is focussed on initiatives that have the potential to defer or reduce future service demand. As such the funding is being used as 'invest to save'.

4.4 Legal Implications, access to information and Call In

- 4.4.1 There are no access to information and Call In implications arising from this report.

4.5 Risk management

- 4.5.1 There is a risk that some of the individual funded initiatives do not achieve their predicted benefits. This risk is being mitigated by ongoing monitoring of the impact of the individual schemes and the requirement to produce exit/mainstreaming plans for the end of the Spring Budget funding period.

5 Conclusions

- 5.1 Adults & Health will continue to submit quarterly returns to DCLG regarding the use and impact of Spring Budget monies as required under the grant conditions.
- 5.2 Locally we will continue to monitor the impact of the schemes and plan towards the exit from the Spring Budget funding period.

6 Recommendations

- 6.1 The Leeds Health and Wellbeing Board is asked to:
 - Note the contents of this report,
 - Note the contents of the Leeds iBCF Quarter 3 2017/18 return to the DCLG, and;
 - Note the content of the Leeds HWB BCF Performance Monitoring return to NHSE for Quarter 3 of 2017/18.

7 Background documents

- 7.1 None.



How does this help reduce health inequalities in Leeds?

The BCF is a programme, of which the iBCF is a part, spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

How does this help create a high quality health and care system?

The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.

How does this help to have a financially sustainable health and care system? The iBCF Spring Budget monies have been jointly agreed between LCC and NHS partners in Leeds and is focussed on transformative initiatives that will manage future demand for services.

Future challenges or opportunities

The initiatives funded through the iBCF Spring Budget monies have the potential to improve services and deliver savings. To sustain services in the longer term, successful initiatives will need to identify mainstream recurrent funding to continue beyond the non-recurrent testing stage.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21

A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

QUARTERLY REPORTING FROM LOCAL AUTHORITIES TO DCLG IN RELATION TO THE IMPROVED BETTER CARE FUND

Section A

A1. Provide a narrative summary for Quarter 3 which follows up the information you have provided in Section A in previous returns. What are the key successes experienced? What are the challenges encountered?

Please note: per advice from DCLG only the top 20 schemes (in terms of overall investment) have been included on the return). The full list of the schemes is:

Asset Based Community Development (ABCD); SkILs Reablement Service; Supporting Wellbeing and Independence for Frailty (SWIFt); Customer Access; Local Area Coordination (LAC); Dementia: Information & skills (online information & training); Falls Prevention; Time for Carers; Working Carers; Prevent Malnutrition Programme; Better Conversations; Alcohol and drug social care provision after 2018/19; Health Partnerships team; Peer Support Networks; Lunch Clubs; The Conservation Volunteers (TCV HOLLYBUSH) - Green Gym; Neighbourhood Networks; Leeds Community Equipment Services; Ideas that Change Lives (ITCL) investment fund; A&H - Change Capacity; Telecare Smartoom; Assisted Living Leeds Volunteer Drivers; Learning & Information Resource in recovery hubs; Business Development Manager for Assistive Technology post; Positive Behaviour Service; Yorkshire Ambulance Service Practitioners scheme; Frailty Assessment Unit; Hospital to Home; Staffing resilience; Business Support for Discharge Process; Respiratory Virtual Ward; Falls Pathway Enhancement (LCH); Transitional Beds; Trusted Assessor (LGI); Trusted Assessor (SJH); Rapid Response

In addition, the following schemes are no longer included in the top 20:

Capacity for transition to strengths-based approaches; Retaining care home capacity during service transformation

Since Q2, Leeds has:

1. Further mobilised a broad transformational programme across Care and Health services funded through the Spring Budget monies
2. Continued to use the spring budget money to reverse planned service reductions that would have otherwise been inevitable (as detailed in our Q1 return to DCLG)

The transformational programme is focussed on initiatives that have compelling business cases to support the future management of service demand and system flow and prevent and delay the need for more specialist and expensive forms of care. This is

founded on the principles of the Leeds Health and Care Plan as described in the narrative of Leeds Better Care Fund Plan (which sits under the Leeds Health & Well-Being Strategy and links to the West Yorkshire & Harrogate Health and Care Plan (STP).

We have prioritised funding for schemes that support our preparations for winter for example: SB49 – Yorkshire Ambulance Service practitioner scheme; SB50 – Frailty Assessment Unit; SB52 – Hospital to home; SB64 & SB65 – Trusted assessors.

Since Q2, a monitoring/accountability structure has been established which:-

- Measures the actual impact of each individual initiative
- Monitors actual spend on each initiative and releases funding accordingly
- Ensures that appropriate steps are being taken to identify ongoing recurrent funding streams after the iBCF funding period ends in cases where initiatives prove to be successful
- Ensures that exit strategies are in place for following the lifetime of the Spring Money funding or if the initiatives that do not achieve their intended results and are ceased.

This programme of initiatives was developed through discussions between the Leeds City Council, the Leeds CCGs Partnership and the local NHS provider trusts and has been locally formally agreed by sign off from the Leeds Better Care Fund Partnership Board. A joint panel of local authority and NHS commissioners and providers convened in December 2017 to ensure that all proposals satisfied the requirements set out above.

The aim of the panel was to bring different system perspectives and constructive challenge to ensure that collectively there was a balanced and holistic assessment of the proposals. It was also an opportunity for Scheme Leads to provide sufficient confidence to the Panel that their schemes are appropriately developed in a number of key aspects, in particular, realisation of benefits.

As part of the follow up to the panel Scheme Leads have been made aware, by letter, of their responsibilities to provide the following on an ongoing basis:

- Submission of the required information on scheme spending and benefit delivery for the quarterly iBCF return to DCLG and NHSE, including the impact (if any) on key national metrics in a timely manner;
- Progress reports on delivery of the scheme and its benefits, including the escalation of issues that are likely to impact upon the success of the scheme, key gateways/milestones reached;
- Any requirements identified by the Leeds Health and Wellbeing Board, via the Leeds Plan Delivery Group to enable it to assess the success or otherwise of the scheme during its lifetime.

They were also reminded that all schemes were expected to be clear on the deliverable benefits (including baseline and targets), milestones and exit strategy. If the scheme did not meet these then ongoing funding would be at risk.

A number of the Leeds iBCF initiatives are specifically aimed at improving system flow by:-

1. Managing demand more appropriately at the 'front door' of the hospital (e.g. Frailty Assessment Unit) and
2. Supporting more timely discharge from hospital (e.g. Trusted Assessors)

In this way, the iBCF is supporting the High Impact Change Model delivery for the city.

The iBCF funding is also being used to support Adult Social Care's mandate to maximise the independence of its citizens through a preventative strength-based approach to social care and linking people to the existing assets in their own communities. The Leeds initiatives are therefore founded on these values:-

- Maximising people's potential through recovery and re-ablement
- Maximising the benefits of existing community assets and Neighbourhood Networks
- Improving the application and uptake of technology

As already outlined in the Leeds Quarter 1 and Quarter 2 iBCF returns, the mandated metrics relating to increasing home care and care packages are at odds with our local ambition. Indeed, we seek to reduce or at least level demand for this statutory provision through our strengths-based approach and through prevention, including that provided by our thriving third sector. Our revised local metrics for iBCF funding reflect this:-

1. Number of bed weeks residential/nursing care commissioned (as opposed to the number of placements in residential) and
2. Number of home care hours relative to residential (non-nursing) care bed weeks

Metrics remain unchanged from Q2.

During Q4 we will be reviewing and adding local metrics which we will be using to monitor overall success of the programme.

This Q3 return has been approved by the Leeds BCF Partnership Board.

Appendix 1 - iBCF (Spring Budget) Q3 2017/18 Return

A2. Provide progress updates on the individual initiatives/projects you identified in Section A at Quarters 1 and 2. You can provide information on up to 5 additional initiatives/projects not cited in previous quarters to the right of the boxes below if needed.

	Initiative/ Project 1	Initiative/ Project 2	Initiative/ Project 3	Initiative/ Project 4	Initiative/ Project 5	Initiative/ Project 6	Initiative/ Project 7	Initiative/ Project 8	Initiative/ Project 9	Initiative/ Project 10
A2a. Individual title for each initiative/project	Falls Prevention (SB14)	Neighbourhood Networks (SB30)	Leeds Community Equipment Services (SB31)	Local Area Coordination (LAC) (SB12)	Transitional Beds (SB63)	Better Conversations (SB22)	Lunch Clubs (SB26)	The Conservation Volunteers (TCV HOLLYBUSH) - Green Gym (SB28)	Positive Behaviour Service (SB44)	Falls Pathway Enhancement (LCH) (SB61)
A2b. Use the drop-down options provided	3. In progress: showing results	1. Planning stage	3. In progress: showing results	1. Planning stage	2. In progress: no results yet	1. Planning stage	2. In progress: no results yet	1. Planning stage	1. Planning stage	2. In progress: no results yet
A2c. You can add some brief commentary on the progress to date if you think this will be helpful (in general no more than 2 to 3 lines).	The schemes have been evaluated internally in the services and significant individual improvement in outcome measures seen.	Start date is anticipated to be 1st Oct 2018	Service commenced spend in Sep 17 this has meant the waiting value for equipment for adults without CHC status £132K rather than £258k it was projected to be.	Apr 18 – specification developed to support the development of embedded Intermediaries with the skill and capacity to support communities and people within those communities		This project would start to draw funds from Apr 18 and end Mar 20	Continues to provide an annual Lunch Club small grants scheme for 2018/19 targeted at older people	Dec 17 Initial funding to underwrite preparation and set up Jan 2018 staff recruited to the 4 posts	Dec17/Jan18 - design team structure; develop Job Descriptions with health colleagues	The LCH Falls scheme will run November 2017 – March 2019; development of accredited Safety Huddles commenced Nov with Safety Huddle coach in post

Appendix 1 - iBCF (Spring Budget) Q3 2017/18 Return

A2a. Individual title for each initiative/ project.

A2b. Use the drop-down options provided

A2c. You can add some brief commentary on the progress to date if you think this will be helpful (in general no more than 2 to 3 lines).

Initiative/ Project 11	Initiative/ Project 12	Initiative/ Project 13	Initiative/ Project 14	Initiative/ Project 15	Initiative/ Project 16	Initiative/ Project 17	Initiative/ Project 18	Initiative/ Project 19	Initiative/ Project 20
SKILs Reablement Service (SB3)	Health Partnerships team (SB24)	Yorkshire Ambulance Service Practioners scheme (SB49)	Frailty Assessment Unit (SB50)	Hospital to Home (SB52)	Staffing resilience (SB54)	Respiratory Virtual Ward (SB58)	Trusted Assessor (LGI) (SB64)	Trusted Assessor (SJH) (SB65)	Alcohol and drug social care provision after 2018/19 (SB23)
1. Planning stage	2. In progress: no results yet	1. Planning stage	3. In progress: showing results	3. In progress: showing results	1. Planning stage	2. In progress: no results yet	2. In progress: no results yet	2. In progress: no results yet	1. Planning stage
Recruitment of the 5 additional SWAs is underway. Anticipated they would be in post early 2018	Temporary funding will enable a period of time for the Council to identify an alternative ongoing funding source	The mobilisation of the St Georges Urgent Treatment Centre Apr 18	Service commenced Nov 17	The scheme is already up and running as was funded originally as part of a government office initiative. Following a robust evaluation funding was extended by agreement through SRAB	ASAP for 3 agency workers to release capacity to commence dedicated work with BRI, HDG and Pinderfields	The project commenced in Sep 17, steering group established Oct 17, model agreed Dec 17	4WTE additional members to be in place from Dec 2017	Scheme already in place - 4WTE additional members to be in place from Nov 17	This project would start to draw funds from Apr 18

Section B: Information not required at Quarter 3

Section C

C1a. List of up to 10 metrics you are measuring yourself against. Automatically populated based on information provided in Quarter 2. Please ensure your password is entered correctly in cell C13. Scroll to the right to view all previously entered metrics. You can provide information on up to 5 metrics not cited previously to the right of these boxes if needed.

C1b. Use the drop-down options provided or type in one of the following 4 answers to report on any change in each metric since Quarter 2:

1. Improvement
2. Deterioration
3. No change
4. Not yet able to report

C1c. Provide any additional commentary on the metric above, if you wish.

Metric 1	Metric 2
Number of commissioned care home weeks (65+)	Percentage of new client referrals for specialist social care which were resolved at point of contact or through accessing universal services'
1. Improvement	3. No change
A range of recent work has led to increased capacity in reablement and step down to home services. This is enabling people greater opportunities to recover and regain independence in the community.	

Better Care Fund Template Q3 2017/18

1. Cover

Version 1

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leeds
Completed by:	Lesley Newlove
E-mail:	lesley.newlove@nhs.net
Contact number:	0113 8431627
Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Rebecca Charlwood

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0

Better Care Fund Template Q3 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board:

Leeds

Confirmation of National Conditions		
National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	Response	If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:	If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q3 2017/18
3. Metrics

Selected Health and Well Being Board:

Leeds

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	Whilst activity is lower than our plan for the year the length of stay of those patients admitted is generally longer	NEA is below plan	None
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	An increased focus upon transferring people from hospital may increase demand on services to support people to regain independence and lead to	The projected figures show that we will meet the target. Work is ongoing to increase capacity across the city in the provision of CIC beds to	None
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	This measure relates to the proportion of people who are still at home 91 days after being discharged from hospital	ASC reablement services have been restructured to provide more capacity	None
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	Increases in DTOCS reported within the Leeds Mental Health Provider. This has risen from an average of 12 in Q4 last winter to an average of 35 in recent months	Agreement of a number of initiatives to support flow through iBCF. Implementation of Community Beds Strategy. Also review of options for provision of out of	None

* Your assessment of progress against the Delayed Transfer of Care target should reflect progress against the monthly trajectory submitted separately on the DToC trajectory template

Better Care Fund Template Q3 2017/18

4. High Impact Change Model

Selected Health and Well Being Board:

Leeds

		Maturity assessment				Narrative			
		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Established	Established	Mature	Mature		Size of hospital and challenge of ensuring consistent approach across all admission routes and wards across two sites	Closer working between integrated Discharge Service and Hospital Social Work Teams to improve discharge planning. Ongoing work to improve assessment prior to admission through	None
Chg 2	Systems to monitor patient flow	Plans in place	Plans in place	Established	Established		Ensuring routine/daily flows of demand data to support whole system responses to fluctuations in demand. Agreement to establish DTOC monitoring arrangements to all	Establishment of agreed daily system flow reporting by all NHS providers. Agreed Mutual Aid and Escalation Policy across all NHS Providers.	None
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established	Established	Established	Established		Expansion from current limited service (Operating in A&E, Assessment and Medical and elderly Wards only) to whole hospital	Agreement to funding increased for capacity. Agreement to review current model with aim to commission new whole systems model in readiness for winter 2018/19	None
Chg 4	Home first/discharge to assess	Established	Established	Mature	Mature		Large number of care home providers offering different approaches to trusted assesment and variable response times with regards to assessment within reasonable	Increased capacity within reablement to support this approach. New community bed capacity now in place which embeds Transfer to Assess Protocols	None
Chg 5	Seven-day service	Not yet established	Not yet established	Not yet established	Not yet established		Equipment Services are operating on a 7 day basis and iBCF monies have been prioritised for Rapid Response Social Workers to maintain a 7 day service during this coming winter.	Beginning to review feasibility of changing to 7 day working for services where there is interdependence between health and social care and changes in behaviour required to realise	None
Chg 6	Trusted assessors	Established	Established	Mature	Mature		Further work is required to understand options for Trusted Assessment for readmission to existing care homes. Main challenges associated with Trusted Assessment by Care Homes. We are	Single assessment form agreed for use by all organisations/professionals assessing patients. iBCF have approved funding to support increase in Trusted Assessor capacity. This will extend	None
Chg 7	Focus on choice	Mature	Mature	Mature	Mature	Progress is being made on developing options for the commissioning of dementia care. It is estimated that up to 30 delayed transfers of care are associated with difficulties in providing	Lack of provision for patients with complex needs notably elederly with complex mental health issues associated with dementia	Dementia Board Workshop to progress need for solution to issue associated with difficulties in out of hospital provision fro dementia patients. Proposals to be developed in current	None
Chg 8	Enhancing health in care homes	Established	Established	Mature	Mature		See issue re dementia above	Number of schemes in place in Leeds. A review is being undertaken to align three Leeds CCG funded care home schemes ensuring best practice of each embedded in new scheme to be	None

Hospital Transfer Protocol (or the Red Bag Scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	Red Bag scheme	Established	Established	Established	Established		The red bags are not always sent from the actual setting at the same time as the patient	Care Homes have responded well to this scheme	None

Better Care Fund Template Q3 2017/18

5. Narrative

Selected Health and Wellbeing Board:

Leeds

Remaining Characters:

18,487

Progress against local plan for integration of health and social care

As articulated in the Leeds 2017-19 BCF Narrative Plan, the Leeds BCF is a contributor to the delivery of the Leeds Health and Care Plan (which in turn forms a strand of the Leeds Health & Well-being Strategy). The Leeds Plan is founded on the development of a Population Health Management approach for the city and all partners have been involved in a series of workshops which has identified the population segments that will be focussed on initially (frailty and end of life.) The new Frailty Unit has been established at LTHT which operates with resources from across health and social care agencies including 3rd sector. It integrates assessment and discharge planning by utilising the skills of staff from LTHT, LCH, Adult Social Care and 3rd sector. Partners are working together to support the commissioning and development of community provision for patients with dementia. This will require agreement to joint commissioning of both clinical teams and independent sector provision.

Our 13 neighbourhood teams continue to work in partnership with other organisations wrapping care around the patient. Each neighbourhood in Leeds is aligned to a Community Geriatrician and integrated neighbourhood team who work with our primary care teams as part of a wider MDT. These teams are providing a greater focus on preventative care and self-management, reducing hospital admissions. Often teams are required to prioritise their caseload to support system flow and respond to urgent and rapid requests.

Remaining Characters:

18,385

Integration success story highlight over the past quarter

A significant area of success in our plan is in respect of implementing a new Community Bed strategy across Leeds. Contracts were awarded for a new Community Care Beds Service (CCBS) in September 2017 following a procurement process led by the Leeds CCGs Partnership in readiness for Winter. The CCBS mobilised on time and has been operational since 1st November 2017. In the first week, 35 patients were admitted to CCBS beds. Capacity has increased to 227 beds across seven bed bases and will cater for both Intermediate Care and a new Transfer To Assess model. The service has been commissioned to provide personalised, proactive care and reablement and rehabilitation and is supported by local general practitioners to provide enhanced cover to beds, community geriatricians and our 13 neighbourhood teams. Over the Winter, teams are being required to ensure that they prioritise their caseloads to ensure support to system flow and admission avoidance.

The pathway into the Community Bed Care Service is being delivered through an integrated approach between Leeds Teaching Hospitals Trust, Leeds Community Healthcare Trust, the Local Authority and the independent sector. The service will now include capacity for hospital 'discharge to assess' patients as well as people requiring active rehabilitation, so that people's longer term care needs can be assessed outside of the hospital environment and reduce delayed transfers of care. The new Community Care Beds Service is grounded within the established integrated Neighbourhood Teams model to ensure smooth transfer for those who are returning home.

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Report of: Leeds Health and Care Partnership Executive Group (PEG)

Report to: Leeds Health and Wellbeing Board

Date: 19th February 2018

Subject: Leeds Health and Care Quarterly Financial Reporting

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues:

This report provides the Health and Wellbeing Board with an overview of the financial positions of the health & care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1).

Key headlines at quarter 3:

- NHS partners are predicting that they will meet the financial targets set by national regulators. However this is heavily dependent on the identification and delivery of local savings, planned for the final quarter of the year.
- Within the City Council the Adults and Health and Children's and Families directorates continue to forecast that their expenditure can be contained within budget. Significant pressure is being felt due to the necessary increase in Care Home fees and the increasing number of Children Looked After.
- There is significant financial risk associated with the plans of all partners, not all of which are fully mitigated.

Recommendations:

The Health and Wellbeing Board is asked to:

- Note the end of year forecast.

1 Purpose of this report

- 1.1 This report provides the Health and Wellbeing Board with a brief overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1).
- 1.2 This financial 'health check' aims to clarify where the current and expected financial pressures are in the local health and care system. This provides the Health and Wellbeing Board with an opportunity to direct action which will support an appropriate and effective response.
- 1.3 This paper supports the Board's role in having strategic oversight of and both the financial sustainability of the Leeds health and care system and of the executive function carried out by the Leeds Health and Care Partnership Executive Group.

2 Background information

- 2.1 In September 2016, the Leeds Health and Wellbeing Board considered a paper entitled 'Towards Better Joint Health and Care Working – A Governance Update'. The Health and Wellbeing Board endorsed a number of proposals within this paper, which included that:
 - The Board has a principal role in the oversight of the financial sustainability of the Leeds system
 - The Board oversee the Leeds Health and Care Partnership Executive Group (PEG) which exists as a meeting of the executive functions for the partnership in relation to the direct health and care system and therefore task it with implementing the Leeds STP
 - The Board receive a quarterly report from the PEG, providing a financial health check for Leeds health and care provision.
- 2.2 The financial information contained within this report has been contributed by Directors of Finance from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Groups.

3 Main issues

- 3.1 At quarter 3 the collective health and care system in Leeds is predicting that NHS control totals will be met and break-even achieved on health and care budgets in the Council.
- 3.2 The plans of all partners include significant risks, some of which are currently not fully mitigated. This particularly relates to the identification and delivery of local savings schemes that are planned to provide significant benefits in the final quarter of the year.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 Development of the Leeds health & care quarterly financial report is overseen by the Directors of Finance from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Groups.
- 4.1.2 Individual organisation engage with citizens through their own internal process and spending priorities are aligned to the Leeds Health & Wellbeing Strategy 2016-2021, which was developed through significant engagement activity.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Through the Leeds health & care quarterly financial report we are better able to understand a citywide position and identify challenges and opportunities across the health and care system to contribute to the delivery of the vision that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest', which underpins the Leeds Health and Wellbeing Strategy 2016- 2021.

4.3 Resources and value for money

- 4.3.1 Whilst the Health and Wellbeing Board has oversight of the financial stability of the Leeds system, the PEG has committed to use the 'Leeds £', our money and other resources, wisely for the good of the people we serve in a way in which also balances the books for the city. Bringing together financial updates from health and care organisations in a single place has multiple benefits; we are better able to understand a citywide position, identify challenges and opportunities across the health and care system and ensure that people of Leeds are getting good value for the collective Leeds £.

4.4 Legal Implications, access to information and call In

- 4.4.1 There is no access to information and call-in implications arising from this report.

4.5 Risk management

- 4.5.1 The Leeds health & care quarterly financial report outlines the extent of the financial challenge facing the Leeds health and care system. These risks are actively monitored and mitigated against, through regular partnership meetings including the Citywide Director of Finance group and reporting to the PEG and other partnership groups as needed. Furthermore, each individual organisation has financial risk management processes and reporting mechanisms in place.

5 Conclusions

- 5.1 Whilst in 2016/17 all health and care partners in the city met the required financial targets this was due to non-recurrent benefits rather than sustainable changes to operational delivery. In 2017/18 partner organisations are predicting that they will again successfully discharge their financial responsibilities but are similarly relying on a range of non-recurrent measures.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the Leeds health & care quarterly financial report.

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7 Background documents

7.1 None



How does this help reduce health inequalities in Leeds?

An efficient health and care system in financial balance enables us to use resources more effectively and target these in areas of greatest need.

How does this help create a high quality health and care system?

Driving up quality depends on having the resources to meet the health and care needs of the people of Leeds. Spending every penny wisely on evidence based interventions and ensuring we have an appropriate workforce and can manage our workforce effectively promotes system-wide sustainability.

How does this help to have a financially sustainable health and care system?

It maintains visibility of the financial position of the statutory partners in the city

Future challenges or opportunities

Future updates will be brought to the Health and Wellbeing Board as requested and should be factored into the work plan of the Board.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21

A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds Health and Care Partnership Executive Group
Forecast end of year financial position as at 31st December 2017

1. Section 1 - City Summary

Sign convention – negative numbers = ADVERSE variances

Forecast for 12 months ended 31st March 2018	Total Income/Funding			Pay Costs			Other Costs			Total Costs			Net surplus/(deficit)		
	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Leeds City Council	615.3	623.9	8.6	142.8	142.4	0.4	472.5	481.5	- 9.0	615.3	623.9	- 8.6	-	-	-
Leeds Community Healthcare Trust	146.7	146.0	- 0.7	103.4	103.7	- 0.3	40.3	39.3	1.0	143.7	143.0	0.7	3.0	3.0	-
Leeds Teaching Hospitals NHS Trust	1,206.6	1,208.1	1.5	682.2	695.6	- 13.4	515.3	501.0	14.3	1,197.5	1,196.6	0.9	9.1	11.4	2.3
Leeds & York Partnership Foundation Trust	150.5	153.0	2.5	109.6	109.6	-	37.3	39.8	- 2.5	146.9	149.4	- 2.5	3.6	3.6	-
Leeds CCGs Partnership	1,194.6	1,194.6	-	9.3	9.3	-	1,185.3	1,185.3	-	1,194.6	1,194.6	-	-	-	-

At the end of quarter 3, each of the partner organisations in the city are forecasting that they will meet or exceed their control total or achieve a break-even position. This is a further improvement over the quarter 2 position. Identified risks relate mainly to the identification and delivery of local savings plans with a significant proportion of these being planned in the final quarter; the impact of winter pressures and potential stranded costs relating to competitive tendering.

2. Section 2 – local variances, risks and mitigation

a. Leeds City Council

The numbers quoted above relate solely to the Adults and Health directorate (which now includes Public Health) and the Children and Families directorate. Both directorates are now forecasting balancing to their budget. In the case of Children & Families this reflects the decision of the Council to provide additional funding to the directorate of £3.7m from reserves outside of the directorate.

The budget for the Adult Social Care directorate has been adjusted for the additional monies allocated by the Chancellor in the Spring budget. Outside of this additional funding, there are pressures of £2.1m on demand led budgets (primarily due to significant increases in care home fees) and projected shortfalls in income, including client contributions to community support services. These are offset by savings elsewhere including projected saving of £1.5m on staffing.

The budget for Children and Families remains challenging although now projected to balance overall. The 2017/18 budget has been amended and now includes additional support of £8.1m compared to 2016/17 to recognise the increase in the numbers of Children Looked After. This results in a budget change of £1.4m against the quarter 2 forecast. Current level of children placed with Independent Fostering Agencies (IFA) is 192, whilst the level of External Residential (ER) placements is 61 children. There is a risk that these numbers continue to rise. The budget for staffing is currently forecast to overspend by £1.0m. A shortfall in income to Children's Centres of £0.9m is forecast and is expected to be partly offset by grants being higher than budgeted. In order to offset these increased pressures the directorate is looking to utilise earned income through the DfE Partners in Practice funding.

b. Leeds Community Healthcare Trust

At the end of quarter 3 the Trust's financial performance remains strong overall; the surplus is £0.3m ahead of the plan. A small overspending on pay has been mitigated by underspending on non-pay. Recurrent CIP delivery continues to be a concern. The forecast outturn position demonstrates that the Trust will achieve the control total surplus of £3.034m. However there are financial risks such as the non-delivery of CQUINS, winter pressures, contract changes and redundancy costs that may have a negative impact in the final quarter.

c. Leeds Teaching Hospitals Trust

The overall forecast has improved by £2.3m since quarter 2; this is due to the receipt of additional winter monies. Progress against the required financial trajectory needed to deliver the best-case year end forecast is positive but there remains a material risk that the Trust will not achieve its financial plan. However, a set of mitigating actions have been put in place and if all of these are successful, the delivery risk will be fully mitigated.

At the end of December the Trust reported an adjusted deficit of £7.2m including STF monies. This year to date deficit was £11.9m better than the quarter 2 position and £13.1m better than plan. Contract income is now £8.8m behind plan. Activity related income is £3.5m ahead of plan offset by an under-recovery on income of £12.3m relating to drugs, blood and devices that are contracted for on a 'pass through' basis which has an offsetting favourable variance included in the expenditure position. Other favourable variances on income reduce the total income adverse variance to £6.3m.

Operating expenditure is £8.5m ahead of plan but this is mainly due to 'pass through' costs mentioned above. Under-delivery on waste reduction has been partly offset by underspending on central reserves; when taken together these are £3.4m behind plan. With the exception of these factors, pay and non-pay budgets are broadly in line with plan. Favourable variances of £4.5m on non-operating expenditure and a lower than expected technical adjustment relating to donated asset income of £6.3m make up the rest of the financial position.

d. Leeds and York Partnership Trust

The Trust remains on plan to achieve its financial forecast. The in-year pressure is linked predominantly to our Out of Area placements (OAPs) and a level of unidentified CIPs. Non-recurrent revenue support for the OAPs has been secured and other run-rate variances are also supporting the underlying position.

e. Leeds CCGs

The Leeds CCG's have submitted balanced plans to NHSE for 2017-18, with a citywide QIPP target of 3% (£34.9m) to achieve this position. The forecast is for a breakeven position. Risks remain regarding system resilience and demand. A key risk is that the QIPP targets remain un-mitigated. For 2017-18 a risk reserve is held to cover this however the CCG's financial position moving forward is untenable without the realisation of this QIPP requirement. The CCG Partnership's Joint Finance and Commissioning for Value Committee and Audit Committee in Common have both requested to oversee a detailed delivery process for the CCG QIPP in the latter half of the year as part of their assurance process.